Means and Strategies

Strategic Goal: *Restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families.*

Medical Care

The Veterans Health Administration (VHA) remains committed to promoting the health, independence, quality and dignity of life, and productivity of individuals with spinal cord injury (SCI) and other disabling conditions. This continues to be achieved through effective and efficient delivery of high quality acute rehabilitation, medical/surgical/neurological care, patient/family education and counseling, psychological, social and vocational care, research and professional training of medical residents and students, student nurses, physical and occupational therapists, and others, directly and indirectly involved in the care of SCI and other disabled veterans.

Special attention is accorded veterans with SCI for a number of reasons and because of the severity of illness and disability associated with spinal cord injury, VHA will continue to closely monitor the performance measure described below to ensure VHA continues to be responsive to veterans with SCI and maximize the potential for positive outcomes of care.

VHA improved the overall care of SCI veterans and coordination of their discharge in the following manner:

- In FY 2001, increased staff at SCI Centers (increase FTE 278.8 in FY 2001);

- Distributed and implemented Clinical Practice Guidelines from the Consortium for Spinal Cord Medicine;

- Conducted annual national SCI-Primary Care team training;

- Made improvements in the SCD-Registry to improve coordination of care;

- Achieved CARF (Rehabilitation Accreditation Commission) accreditation for acute SCI&D rehabilitation programs at 19 of 20 SCI Centers;

- Continued identification and translation of best practices in SCI&D by SCI QUERI;

- Expanded direct outreach to patients with SCI&D to increase proportion of influenza and pneumococcal vaccinations;

- Distributed VHI-SCI Continuing Medical Education Project to enhance primary care knowledge of SCI&D issues;

- Improved access to care within patients' communities.

Closely related to restoring the capability of disabled veterans to the greatest extent possible, are VHA's efforts to keep or decrease the rate of delayed prosthetic orders so as to provide veterans with needed orthotic and/or

prosthetic devices in as timely a manner as possible. This was accomplished by continually monitoring VA Medical Center (VAMC) and Veterans Integrated Strategic Networks (VISN) performance on a monthly basis, as outlined in the Network Directors' annual Performance Contract, continued automation and augmentation of the National Prosthetic Patient Database (NPPD) with Computerized Patient Record System (CPRS) and greater implementation of group-buying power or "blanket purchase agreements" of prosthetic devices. The implementation of the NPPD with CPRS provided the means to process prescriptions in a more timely fashion, reducing the number of hardcopy prescriptions while increasing automated functionality. VISNs and VA Medical Centers also authorized a substantial amount of overtime and compensatory time to curtail delays. In addition, the Prosthetic Program nationally realized an overall increase in field-based staffing which provided additional resources necessary to fulfilling prosthetic orders during a time of significant increases in workload. Compared to FY 2000 data, Prosthetic and Sensory Aids Service sustained a 19 percent increase in obligations and a 23 percent increase in the number of orders received in FY 2001 while maintaining a rate of delay below the projected performance level (1percent vs. projected 2 percent).

Severely Mentally ill, including PTSD, recovering Substance Abuse and/or Homeless Veterans are also special populations of veterans for whom VHA is committed to improving care, living arrangements and quality of life. Central to many is the ability to find and keep both a secure or independent living arrangement and a job, once they have substantially completed either an inpatient and/or outpatient treatment program. For some, balancing work and life maintenance activities and responsibilities needs to be interwoven with continuing medical and psychosocial treatment. VHA program effectiveness is a function of the complex array of conditions and psychosocial issues, level of veteran functioning and impediments these veterans must learn to manage to become and remain employed. VHA is continuing to seek ways to improve our service to veterans to increase the probability of their success. VHA is committed to identifying, via outcomes monitoring, the best approaches to treating PTSD patients that result in the best possible health and psychosocial outcomes for this special population subgroup. VHA placed increased emphasis on outcome monitoring in FY 2001 and will continue to do so in FY 2002. Homeless veterans are particularly challenging to identify and work with; however in keeping with the Secretary's stated priority, VHA will continue to seek ways to communicate with these veterans after initial care and treatment to improve the probability that these veterans will continue to be as self-reliant and successful as possible. Domiciliary care and community care/support programs continue to offer needed alternatives to institutional care, once immediate health needs are met.

VHA is also planning to further pursue interagency coordination with VBA and NCA to enhance VA's Vocational Rehabilitation (VR) Program. VHA has

several post-inpatient hospitalization after-care and transitional programs that provide opportunities for recovering and disabled veterans to effectively re-socialize, acquire independent or secure living arrangements and demonstrate positive work skills and habits in protected environments and programs such as Compensated Work Therapy and Incentive Therapy. VHA continues to need volunteers to augment hospital and clinic operations and recovering veterans often are the ideal candidates, whether from within VHA programs, or emanating from VBA's Vocational Rehabilitation program. In turn, as veteran skills and preferences indicate, VHA VR program veterans may find it ideal to work in VBA and NCA.

Compensation and Pension

The Department continues striving toward our vision of improved performance in claims processing. Initiatives dedicated to this effort have been both numerous and diverse, but all with one common goal – enhancement of the claims process. As more in-depth analyses of the VBA process are completed, we expect to further streamline our endeavors in order to achieve our strategic target. Our most important initiatives during 2003 include the following:

- **Pension Consolidation --** This initiative includes consolidation of all existing pension programs, death compensation and parent's DIC into three centers. Consolidation through pension centers will begin with two paper-based environments and one imaged environment. Migration to a fully paperless environment for all sites is planned over five years. A skilled staff solely devoted toward processing one benefit will improve decision quality, minimize the pending time for a pension claim and expedite the delivery of benefits.

- **Virtual VA --** The Virtual VA Project replaces the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a thin client (web-based) solution. It will provide a long-term solution to improving the quality of claims processing for veterans and their dependents through enhanced file management, a reduced dependency on paper, and increased workload management across the business enterprise.

- **Training and Performance Support Systems (TPSS) --** This initiative develops four comprehensive TPSS for the core service delivery positions of the reengineered environment. The four systems are for a) basic rating (RVSR); b) veterans service representatives (VSR); c) journey level rating specialists to include the Decision Review Officers; and d) field examiners. At this time, ten modules have been released to all regional offices.

- **Systematic Individual Performance Assessment (SIPA) --** SIPA complements our national quality assurance program, Systematic Technical

Accuracy Review (STAR), and brings performance assessment and accountability to the journey-level individual. Systematic individual performance assessments will bring accountability to the journey-level individual and serve as an internal control mechanism to minimize the potential for fraud since performance reviews will focus on program and data integrity concerns, proper signatures, and supporting documentation.

- **Compensation and Pension Evaluation Redesign (CAPER) --** As we head into the 21st century we are aware of heightened expectations from customers, rapid change in technology, increasing complexity of decisions, extremely tight labor markets, and a VA workforce which will see significant turn over in the skill-intensive, rating veterans service representative (RVSR) position. Current experience documents that the time to fully train an individual for this position can take up to three years. The CAPER team will review all phases of the C&P claims process from the initiation of medical evidence development to the point a rating decision is completed. This project will determine what the optimum exam and other medical evidence gathering processing should be and how they can be integrated to improve the overall disability evaluation process. Furthermore, the team will gather and evaluate medical evidence associated with disability claims and construct a revised model for evaluating disabilities.

- **Benefits Replacement System (Core EP) --** VBA will pursue an incremental strategy as the most effective means to complete the development of the C&P payment system. The strategy provides for a sequential application development effort, specifically, the incremental development and integration of functional modules or components. The process is divided into three primary areas: 1) Development, Case Management and Tracking; 2) Rating; and 3) Award, Payment and Accounting. This functional division provides opportunities for defining and deploying incremental applications to the new operating environment. Migration from the Benefits Delivery Network (BDN) is achieved in functional components rather than as a total system replacement.

VA has taken steps to offset the impact of legislative and regulatory changes on timeliness and accuracy by implementing countermeasures using available resources. The Under Secretary for Benefits presented the Department's strategies in a satellite broadcast to regional offices in March 2001. As of this time, we have successfully implemented the following measures in FY 2001:

- In March 2001, VBA launched its centralized training initiative, called Challenge, to train these new hires. Challenge is now the standard for training future hires.

- As of December 2001, a total of 1,298 Veterans Service Representatives (VSRs) and Rating VSRs have been hired. All have gone through the Challenge 2001 training program.

- VBA reached an agreement with the Board of Veterans Appeals (BVA) concerning remand development. By January 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices.

- Nine Resource Centers were established to focus on specialized claims processing.

- The St. Louis Helpline was expanded and fully operational by February 2001.

- Several national decision notification letter packages prepared in an enhance Personal Computer Generated Letters (PCGL) were released in April and in November 2001.

- A work group has developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.

- The amendment to the Code of Federal Regulations (38 CFR 3.103) allowing VBA's decision-makers to gather evidence by oral communication, from beneficiaries currently on the rolls, was published in the Federal Register on April 20, 2001.

- The Compensation and Pension Records Interchange (CAPRI) application that allows VBA's decision-makers to successfully obtain medical records from the Veterans Health Administration database was successfully tested in January 2001. This application will be available to all 57 regional offices.

- VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint medical Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify problems, their root causes and the tools and procedures needed to improve the quality and timeliness of C&P medical examinations.

 VBA also expects to successfully implement the following countermeasures in FY 2002 – 2003:

- Providing field offices relief from doing local STAR reviews. By January 2002, a national STAR office located in Nashville, Tennessee will be fully operational. VBA has selected most of the subject matter experts for this effort. This office will absorb the additional national reviews in order to take into account local reviews that will no longer be conducted by the field offices.

- The centralized processing of pension maintenance workload will begin in January 2002. Initially, the processing will focus on eligibility verification reports. VBA expects that centralized processing will address all pension maintenance workload by the end of FY 2003

- Virtual VA's imaging technology will be fully tested in FY 2002 at the pension maintenance center in Philadelphia and then deployed to the Milwaukee and St. Paul pension maintenance centers in FY 2003.

- VBA has been working closely with the DoD on two major initiatives: the exchange of their records through imaging technology and the creation of a joint separation examination and disability evaluation protocol. It is expected that both of these efforts will be ready for testing by the end of FY 2003.

Vocational Rehabilitation and Employment (VR&E)

Because the Employment Specialist (ES) pilot program was a success, the VR&E program through succession planning is changing the skill mix of its staff from vocational rehabilitation specialist to employment specialist.

With employment specialists and case managers working outside the normal structured working environment, each individual will be supplied with a laptop and other equipment, as found necessary. These positions will require flexibility in work schedules and the ability to access systems during irregular work hours, whether in the office or at other locations, in order to best meet the veterans' needs.

Access is focusing on improving the channels of communication between the veterans and the case managers by the use of various methods of information technology and providing the case managers with the tools to perform their jobs regardless of their location. Tools such as the utilization of laptop computers and personal digital assistants (PDA's) will improve the staff's ability to communicate with the office and VBA and/or VA IT systems for immediate access/retrieval of information when assisting the veteran at any location. The program is expanding the locations and methods for which veterans may contact a program representative (i.e., increased outbased locations, redesign of web site, purchase of required information technology equipment for staff, and partnership with other federal agencies).

VR&E is placing emphasis on the training of employees throughout the program to improve the staff's competency and skill level in support of providing the best possible service to veterans. Training is being offered through several methods including regional training for all clinical staff, in-house training at each office, and continuous Corporate WINRS training for both the VR&E personnel and finance employees who support the VR&E program.

Corporate WINRS is a recently deployed information management system that will continue to be enhanced with improvements that will support the

VR&E program and its ability to service the disabled veterans whenever our expertise and services are needed. As program needs and regulations change or systems that interface with Corporate WINRS are modified, enhancements will continue to be developed in order to comply and provide optimal service for both the veterans and the employees.

A special task force team is being established to conduct a study of the impact and effects of the Enhanced Montgomery GI Bill, as well as the impact that regulatory and legislative changes in Compensation and Pension may have on veteran entitlement to VR&E benefits and services.

Strategic Goal: *Ensure a smooth transition for veterans from active military service to civilian life.*

Medical Care

VHA is continuing to pursue, with VBA and DoD, the expansion of opportunities to link up with current military personnel who will be honorably discharged from service within a six-month window, to expedite completion of their medical record and medical evaluation of need for continuing care under VA auspices. A second facet of this initiative is to ensure the timely and secure transfer of military patient records to the facility of choice made by the military personnel being discharged.

Education

VA's Education Service mails a brochure, "Focus on Your Future with the Montgomery GI Bill," to men and women in the Armed Forces. Similar mailings are planned at specific points throughout each individual's military career. This brochure provides a general description of MGIB education benefits. It also has information to help service members, who might already be eligible for MGIB benefits, make a decision to enter training and use their earned benefits.

VA has developed brochures for specific situations, also. For example, VA developed a brochure in 2001 to highlight a new education benefit, reimbursement for licensing and certification tests, enacted by Congress. As veterans learn of this new benefit, they can determine whether it affords them opportunities for advancement in the workplace. Additional targeted brochures, as needed, will advise veterans of other opportunities.

The development and installation of TEES (The Education Expert System) is a major multi-year initiative started in 2000. When fully operational, it will improve timeliness and enhance customer service by automatically processing more claims (up to 90 percent of those received electronically) without human intervention. A small, proof of concept, application has been developed and deployed. Some enrollment information, received electronically from educational institutions, is now processed by a prototype rules-based expert system without human intervention. VBA contracted for and received an assessment of how to

successfully process up to 90 percent of all education claims automatically. A capital investment application was then approved and permission granted to proceed with the initiative. Development efforts began in 2001 and will continue through 2007.

While performance suffered in 2000 and continued into 2001, steps have been taken to reverse that trend. For instance, recently hired employees, representing almost 40 percent of all decision makers in April 2001, will become more proficient and contribute significantly to reducing the number of days it is taking to process a claim. In addition, overtime will be used during heavy enrollment periods to increase the volume of claims completed as soon after receipt as possible.

Payment accuracy can be improved by:

- monitoring claims processing results;

- identifying trends that inhibit accurate processing;

- providing the necessary training for personnel to improve their decision making skills.

The hiring and training of additional new staff has created a setback in progress toward our strategic objective of a 97% payment accuracy rate. The electronic training initiative being pursued will facilitate uniform and consistent training. As training interventions continue and new hires gain experience, performance in this measure should improve once again.

Feedback from earlier surveys led VBA to implement nationwide toll-free service for education beneficiaries. They now receive toll-free telephone service by dialing 1-888-GIBILL1 (1-888-442-4551). They are first connected to an automated response system that provides:

- general information;

- answers to frequently asked questions;

- recent payment information;

- limited, beneficiary specific, master record information.

Callers can opt to speak to an Education Case Manager at any time during the call if they want personal attention.

Two issues hampered customer service improvements after implementation of toll-free phone service. First, automated responses have not curtailed the number of callers seeking to speak with an Education Case Manager. Second, call volumes have been larger than originally anticipated. As a result, resource requirements were understated resulting in an inordinate number of callers unable to complete their calls. VA examined resource needs. Seasonal employees

will supplement permanent staff during peak periods to improve service. To divert some traffic away from telephones, VA is exploring electronic alternatives that provide services and satisfy education beneficiaries. While there has been an education service web site for several years to provide VA related information, plans have been developed to enhance usage of the site. In addition to resolving inquiries electronically, the site is being expanded to allow for some veteran self-service. The first application, Web Automated Verification of Enrollment (WAVE), is now accepting monthly self-verifications of enrollment with minimal human intervention. Other self-service actions (such as address changes) will be added.

Housing

The program emphasis is on developing and implementing information technology solutions to provide more timely service to our customers at a reduced cost. Important benchmarks are the quality and efficiency of service provided by private entities because they set the level of expectations for all real estate transactions.

VA relies heavily on the lending industry to deliver the home loan benefit. Ultimately, the level of veteran satisfaction is directly dependent on how well VA can meet the expectations of lenders, builders, real estate brokers and appraisers. This means adapting the delivery of our services to industry practices and making timely changes as technology generates improvements in the loan origination process. Current plans call for major enhancements in the following areas: loan funding fee collection and reporting, automated determination of eligibility, appraiser assignment and property valuation, and e-commerce appraisals, loan applications, default reporting and foreclosure processing.

Some veterans, like other homeowners, experience financial difficulties that may cause them to default on their home loan. When this occurs, VA strives to help veterans retain their homes through loan servicing efforts. Besides counseling, VA may intervene directly on behalf of the veteran to work out a repayment plan. In limited circumstances, VA may buy the loan from the holder and the veteran will make future payments directly to VA.

To improve VA's ability to effectively assist veterans who are delinquent on their mortgages, VBA needs to implement state-of-the-art information technology designed for this specific purpose. There was a need to automate the default servicing and foreclosure management so that VA staff can direct efforts towards helping veterans avoid foreclosure. An automated system was substantially developed and implemented in order to track the variety of actions taken by VA, lenders, and borrowers during the default period. This system automates routine and redundant activities, improving efficiency and allowing employees to concentrate on supplemental loan servicing. It also allows for an earlier analysis of the appropriateness of the different alternatives to foreclosure.

A redesign effort is planned to update the requirements for and processes involved in the application. These changes will increase the utility of the application, provide more accurate data, and improve customer service and workload management. The benefits of the redesign effort will ultimately cause an increase in the FATS (Foreclosure Avoidance Through Servicing) ratio.

Strategic Goal: *Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.*

Medical Care

VHA's quality of care is ensured through monitoring many aspects of care and implementation of clinical practice guidelines. VHA ensures the consistent delivery of high quality health care by also implementing standard measures for the provision of evidence-based care by focusing on the use of both a Chronic Disease Care Index (version II) and a Prevention Care Index (version II). These indices are based on recommendations for the performance of specific processes, provision of certain clinical services or achievement of (proxy) patient outcomes that are known, through rigorous research and literature reviews, to improve health outcomes.

The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, schizophrenia and tobacco use cessation. A large percentage of veterans have one or more chronic diseases and the improved management of chronic diseases results in improved health outcomes to veterans.

The CDCI II is a composite measure that reflects VHA's compliance with 23 separate clinical interventions associated with the eight diseases/conditions noted above.

The prevention of major illness and disabling conditions -- or even death -- has been demonstrated by VA to be one of the most cost-effective and quality of life-affirming activities of the agency. VA demonstrated it superior rate of immunizing against both influenza and pneumonia in FY 2000 -2001 and, by extrapolation, led the nation in preventing unnecessary death and infirmity from influenza and pneumonia. The majority of preventable diseases can be identified through early and appropriately frequent screening, continual education and counseling aimed a high risk factor identification and behavior modification. Through its education and screening tests, VA urges veterans to become aware of ways in which health can be enhanced, and encourages each person to assume active responsibility to achieve this performance goal. The program goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the likelihood and burdens of suffering, costs, and resource availability in chronic disease care.

VA's PI II includes several indicators that allow VA to assess its overall performance in disease prevention. This composite index characterizes how well VA follows national primary-prevention and early-detection recommendations for several diseases or health factors that significantly determine health outcomes: Immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening.

VA implements effective preventive measures through the following activities:

- Implementation of new and/or refined clinical practice guidelines;

- Education of staff and patients on the importance and benefits of prevention;

- Monthly monitoring of local VISN and VAMC level performance using checklists to ensure prevention activities are accomplished as scheduled for high risk and other patients as needed; and

- Empowerment of primary care teams with responsibility and accountability for local implementation of the PI II.

Patient satisfaction with VA health care service is of paramount importance to VA and is measured in several ways. These data are routinely collected and analyzed. Patient satisfaction survey frequency is scheduled to increase in late FY 2002. VHA will be increasing the frequency of administration of the inpatient satisfaction survey from an annual cycle to a semi-annual cycle. Along with changing the instrument as outlined before, VHA will increase the frequency of administration of the outpatient satisfaction survey from two times per year to four times per year. This increased frequency of survey will give VA Medical Centers the ability to better support progress in improving patients' satisfaction. The Office of Quality and Performance has also developed and deployed a Patient User Local Satisfaction Evaluator (PULSE), a hand-held, touch-screen device that can be used to gather satisfaction data at the point of care, empowering direct care providers and managers to support improvement more directly. PULSE affords VA Medical Centers the ability to administer recurring surveys as often as they choose (e.g., daily). By emphasizing the importance of overall satisfaction and implementing the PULSE, VHA should see improvement in overall patient satisfaction.

Further, older survey processes will be replaced with the Survey of Health Expectations of Patients (SHEP) process. The SHEP process will allow VHA to integrate and analyze clinical performance, functional status, and satisfaction data gathered from various VHA processes. This integration will provide more meaningful information, especially as it relates to cohort analysis.

The FY 2001 satisfaction measures have been categorized as:

- Proportion of veterans with SCI rating VA health care as 'very good' or 'excellent' (only an inpatient survey is available in FY 2001)

- Proportion of all patients rating VA health care as 'very good' or 'excellent' (inpatient and outpatient)

- Percentage of patients who report problems with the Veterans Health Service Standards (VSS) regarding:

    o Patient education

    o Visit coordination

    o Pharmacy services

    o Health care decision-making

- Percentage of patients rating Vet Centers as 'very good' or 'excellent'

With regard to SCI inpatient satisfaction, VHA achieved, in FY 2001, a level of 53 percent against a projected FY 2001 goal of 60 percent. While this was one percentage point better than FY 2000's attainment level, in retrospect, it appears that improving SCI veterans' satisfaction will take more attention and resources and that FY 2002's projected level needs to be more modestly scaled. This appears prudent given VHA's balancing of resources in constrained economic times and dealing with key staffing shortages in the national health care arena. VHA will conduct focused reviews of results and problem scores.

The Overall Quality measure from the Inpatient Veterans Satisfaction Survey (VSS) is a single item question that asks patients to rate the quality of care they received during their most recent hospital discharge from one of six bed sections (i.e., Medicine, Surgery, Psychiatry, Neurology, Spinal Cord Injured, or Rehabilitation Medicine) on a five-point scale from Poor to Excellent. The FY 2001 inpatient satisfaction score ("Percent of patients rating health care service as very good or excellent") was 64%. When evaluated using the traditional private sector methodology of including 'good' as well as 'very good' and 'excellent' the overall inpatient satisfaction rate increases to 82 percent for FY 2001.

Analysis was conducted to determine which Veterans Service Standard(s) and which questions have the highest correlations with Overall Quality. The VSSs that have strong correlations with the Overall Quality rating include Patient Education/Information, Family Involvement, Preferences, and Transition; challenges within any one of these areas can adversely impact a given VISN's performance in the Overall Satisfaction measure itself.

The Overall Quality measure from the Ambulatory Care Veterans Satisfaction Survey is a single item question that asks patients to rate the quality of care they received in the outpatient setting over the past two months on a five-point scale from "Poor" to "Excellent". The FY 2001 Ambulatory Care

satisfaction score on this measure was 65%. When evaluated using the traditional private sector methodology of including 'good' as well as 'very good' and 'excellent', the overall ambulatory care satisfaction rate increases to 90.7% for FY 2001.

The FY 2001 performance on the percent of Veterans Service Standard (VSS) problems reported per patient was only slightly different from FY 2001 scores. For FY 2000, the patient education, visit coordination, and pharmacy performance was 29.8 %, 15.6 %, and 16.1 %. In FY 2001, the performances were 29.8 %, 15.8 %, and 16.1%, respectively.

Note that with this measure, "positive achievement" is defined as having a lower problem score than the targeted level. Dramatically improved "pharmacy" satisfaction (compared to FY 1999 score) is attributed to full implementation of VHA's Consolidated Mail-Out Pharmacies, which can minimize the number of trips by patients to the nearest VAMC or Community Based Outpatient Clinic (CBOC) for prescription refills through utilization of VHA's mail-out system.

The VSS representing Patient Education/Information assesses the percent of problems reported by patients relating to VHA's patient education/information. VHA's patient education/information enterprise requires that healthcare entities have the optimal mix of information technology support, teaching media and effective teachers that can best meet the learning needs of their local patients. Despite these challenges, improvement (decrease in the percent of patients reporting problems) was realized in three of the seven questions from the 2000 survey results. The issues needing focused attention within this VSS are ensuring the patient understands: 1) side effects of medications and, 2) what to do if problems or symptoms re-occur or get worse. It is noteworthy that 17 VISNs improved performance on this standard, illustrating the commitment by VHA to address and improve performance for the Patient Education/Information VSS.

The VSS representing Visit Coordination relates to the communication of test results, follow-up and referral appointments, and whether or not the patient was given information on who to contact for information after the patient's visit. VHA has achieved a high level of success in coordinating follow up and referral appointments, as problem rates in these areas are remarkably low at only 4 percent (i.e., 96 percent success rate). The issues needing focused attention within this VSS, however, include 1) explaining to patients when and how tests results can be obtained and, 2) who to contact with additional questions post visit. The areas of progress noted above reflect active and effective interventions within all levels of VHA; the remaining challenges suggest that local VA Medical Center leaders may not have adequate tools to assess the impact of local improvement efforts.

VHA met the planned performance levels for the two sub-categories under "health care decision making": patient involvement in decision-making (32

percent) and information on condition/treatment (35 percent). The current survey method and sampling procedure was considered problematic and an interdisciplinary VHA group of clinicians, patient care advocates and statistical sampling experts worked throughout FY 2001 to be ready to roll out the Omnibus Survey in the Second Quarter of FY 2002. VHA expects to start compiling and assessing results in the Fourth Quarter of FY 2002 and in ensuing months.

The Readjustment Counseling Service in VHA has taken steps as necessary and appropriate to preserve core program design features. VHA attained a phenomenal satisfaction rate of 99.73 percent against a projected target level of 95 percent for this measure in FY 2001 in the Readjustment Counseling Service's satisfaction survey. The original design features for the Vet Center program included patient-friendly, community-based facilities largely staffed by veteran service providers. Vet Center Team Leaders locally plan the mix of counseling and outreach services to address the specific needs of the local veteran population. Also, priority is given to accommodating services to the needs of high–risk veterans, to include high-combat exposed, physically disabled, women, ethnic minorities, rural and homeless veterans. Vet Center outreach plans, the level of client satisfaction, the proportion of high-risk veterans among the Vet Center's client caseload maintained at representative levels, and the Vet Center's level of physical visibility and ease of access in the community are subject to ongoing inspection during annual Vet Center quality audits. The program ensures rapport with local veterans by maintaining employees with veteran status at approximately 70 percent of the program's more than 940 total staff. In addition, over 60 percent of the staff that provide direct service to veterans are themselves veterans of a combat theatre of operations. Also relevant is the fact that the program has memorialized its core features in its statement of program purpose, mission and service values providing staff with an easily communicated charter containing the program's unique culture.

VA seeks not only the formal survey results, but actively solicits and obtains veteran and family feedback through focus groups, utilization of Management Assistance Councils to VISN leadership, addressing and analyzing complaints, direct inquiry (correspondence) and comment/suggestion cards. By utilizing these and other means to gauge veteran and family satisfaction, VA can effectively modify its practices and improve its performance goals and measuring instruments.

Access and Waiting Times are key to enabling VHA to improve its patients' perceptions of the quality of care and their overall satisfaction with it. VHA established in FY 2000 and continuing into the future, a set of performance goals titled "30-30-20" and "24/7". These refer, respectively, to when a patient can schedule a non-urgent primary care visit (within 30 days) or a specialty care visit (within 30 days), how long they must wait once they arrive to be seen by a

practitioner (20 minutes), and patients being provided with telephone access to a nurse advisor/referral system on a 24 hour/7 days a week basis. VA's set of service and access performance measures are designed to provide personalized care when and where it is needed, within certain parameters, and in ways that are creative, innovative, and cost-effective. Timely service ensures care is received when it is needed. Providing care in the manner most convenient to the veteran enables us to provide care where it is needed and wanted. The 30-30-20 goals remain a part of Network Director's annual performance contracts and although VHA has made significant improvements in waiting time performance, there remains a need to improve access in two main sub-groups: new enrollees and some specialty care areas. Further monitoring and action is being taken in those areas.

Just some of the many initiatives that VA is pursuing to reach these goals, within anticipated budgetary constraints, include:

- Training or retraining existing transferable staff from inpatient to outpatient care;

- Implementing fully the Institute for Health Care Improvement initiatives and other no or low cost process improvements;

- Where appropriate, adding mental health care to existing CBOCs and planning for this care in new ones;

- Assessing the need to add Geriatrics to existing and new CBOCs;

- Increasing the number of contracts for specialists to provide services to veterans;

- Renovating infrastructure in existing facilities to ensure that at least two exam/treatment rooms are available per clinician providing care on a given day;

- Continue to develop transplant-sharing agreements;

- Continue to update and proliferate computer-based technology to be more cost effective and increase access;

- Continue to provide outpatient medication dispensing technology in community-based outpatient clinics and hospital-based clinics.

In addition to the above noted access and waiting time performance measures, VHA also monitors and strives to increase the number of enrolled veterans with access to home and community-based care (H&CBC). VHA increased the number of veterans served from 14,111 in FY 2000 to 16,150 in FY 2001. This represents a 14.4 percent increase over the baseline year's results. This has been due to sustained emphasis communicated to VISNs as a result of the strong continued Congressional interest in Long-term Care program expansion. At the local level, all Networks recognize the need for expanding H&CBC and all

long-term care services based on the demographics of the veteran population who use VA primarily for their health care. VHA will continue to emphasize expanding access to the long-term care continuum in FY 2002. The introduction of In-home Respite Care will also add to the mix of services available under the H&CBC umbrella.

Patient Safety remains of utmost importance to VA. VA is committed to continuously improving the culture and outcomes of patient safety in its health care facilities. VA has utilized Root Cause Analysis (RCA) as a means to understand the origins and circumstances of safety problems. RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance related to adverse events or "close calls" involving VA patients. VHA achieved its planned performance level of 95 percent implementation for this measure and has decided to replace this measure in FY 2002 with one that will measure the development of a contingency plan if lose the electronic ability for Bar Code Medication Administration (BCMA). BCMA reduces the number of medication errors by using a computer readable bar code with each medication administered.

VHA's National Center for Patient Safety reports the following: For 2001, nationally ninety-nine percent (99 percent) of the root cause analysis reports (RCAs) were submitted within forty-five (45) days or by the date of the granted extension. This information reflects RCAs that were started on or after January 1, 2001 and completed by July 31, 2001. It also reflects RCAs that received a high score based upon their severity and probability rating, and were individual as opposed to aggregated RCAs. This period for evaluation was chosen since the process for requesting and receiving extensions was established and fully operational by January 1, 2001. July 31, 2001 was chosen as the cutoff date so that NCPS could provide performance data for FY 2001 in a timely manner and accomplish the following tasks: perform analysis, develop reports, disseminate information to the Networks to confirm the accuracy of the data, and submit final reports.

Means and strategies used to achieve the performance goal including the management efforts that led to the actual level of performance: NCPS provided ongoing training and assistance to front line staff, managers, facility directors, and VHA leadership to support efficiently completing RCAs. NCPS' methods of communication vary from the structured and formal, to the very informal and spontaneous. The NCPS strategy is to continue to actively solicit success stories and then develop these into information that can be acted upon, disseminating this advice through a variety of means. NCPS employs its newsletter, the NCPS website, the monthly conference calls, and stand-alone PowerPoint presentations to reinforce this message. Such efforts have included:

- Project management tools with specific RCA tasks and proposed timelines;

- Shared stories on how various teams have succeeded in completing timely RCAs;

- A review and analysis of the 15 top reasons for requested extensions, and NCPS suggestions for addressing these roadblocks;

- Ongoing training through national and regional locations;

- Open forum on monthly national calls to discuss timeliness issues;

- Regular briefings to VHA and Network leadership on patient safety.

Insurance

In order to fulfill our mission of providing insurance coverage in reasonable amounts at competitive premium rates, Insurance has made several program enhancements to our programs over the past year. As a result of legislation and administrative actions, improvements to the Servicemembers' Group Life Insurance (SGLI) and Veterans' Group Life Insurance (VGLI) programs include increasing the maximum amount of SGLI coverage available to $250,000, extending SGLI coverage to spouses and children, reducing VGLI premium rates and offering Beneficiary Financial Counseling Service (BFCS) to SGLI and VGLI beneficiaries. We capped Service-Disabled Veterans Insurance (S-DVI) term premiums at the age 70-rate and now provide cash values for National Service Life Insurance (NSLI) and Veterans Service Life Insurance (VSLI) age 70-premium term capped policyholders. In addition, we developed outreach initiatives and are beginning to implement increasing participation of eligible veterans in the Veterans Mortgage Life Insurance (VMLI), VGLI and S-DVI programs.

Insurance has taken various steps to recruit, develop, and retain a competent, committed and diverse workforce that provides high-quality service to veterans and their families. To this end, the Insurance program is undertaking a major training initiative named Skills, Knowledge, and Insurance Practices and Procedures Embedded in Systems (SKIPPES) that calls for 13 separate training initiatives to be developed through 2005. SKIPPES will be composed entirely of standardized materials developed by a group of subject matter experts in collaboration with experts in training methodology. This standardization will result in lower error rates, since every technician will be taught the correct processing procedures rather than relying on individual instructor expertise. Employees will gain confidence from their improved performance when using the imbedded tools the system will provide. This will result in more accurate and timely processing of work, thus improving customer satisfaction. As part of succession planning we have utilized the Presidential Management Intern (PMI) program and the Outstanding Scholar Program (OSP) in order to recruit highly skilled, motivated personnel for mid-level staff positions. The PMI program requires a candidate to have completed a master's or doctoral-level degree from

an accredited college or university; it is designed to attract outstanding graduate students from a wide variety of academic disciplines to the federal service. The OSP is open to college graduates who have a grade point average of 3.5 or higher, based on a 4.0 scale, for all completed undergraduate courses, or who have graduated in the upper 10 percent of their class. Insurance has been very successful in attracting and retaining qualified employees through these programs.

Insurance has utilized information technology to improve the service we provide to our policyholders. Our major technology initiative is the Paperless Processing initiative. Paperless Processing is an imaging system that provides electronic storage of insurance records, on-line access to those records and electronic workflow. Part of this initiative consists of a three-year effort to image all 2.1 million insurance beneficiary and option (B&O) forms of record. After all B&O's are imaged, the need for paper folders will be eliminated. This will save $1.2 million a year in folder handling and storage. This initiative will also improve timeliness and quality of service while reducing the cost to policyholders. When fully installed, this system will reduce the time required for processing death claims and providing other vital services, thus improving customer satisfaction. In addition to faster processing, updated B&O forms ensure that more policies are being paid in accordance with the insured's wishes. Old beneficiary information sometimes results in situations where the beneficiary cannot be found, often requiring lengthy adjudication of claims. Another important initiative is the Insurance Self Service. This web site initiative allows policyholders, with the use of a Personal Identification Number (PIN), to view basic policy information online via the Internet at our web site "**www.insurance.va.gov**". Policyholders have access to their policy description, dividend amount, premium payment status, cash and loan values and the date of their last beneficiary designation. Policyholders can also request a mailed copy of their insurance policy statement via the web site. In future phases of this initiative, policyholders will be able to make certain account changes, such as address and dividend option changes, complete certain electronic applications, and view their beneficiary designation.

Insurance has also improved service to policyholders by streamlining its program. Over the last few years we merged the program into one centralized operation. We consolidated the St. Paul Insurance Center into the Philadelphia Insurance Center, and merged the Systems Development Center into the Insurance Service. Along with the Benefits Delivery Center, co-located in Philadelphia, Insurance is now a 100 percent centralized operation. This centralized operation of headquarters, field operations, information technology and systems delivery along with a nation-wide toll-free service, has helped the Insurance Program become a world-class organization that meets or beats all industry benchmarks at a lower cost than the average industry costs. An example

of this service can be found in the recent study of death claims conducted by the American Customer Satisfaction Index (ACSI) and the University of Michigan. Death claims are considered one of the most important services provided by Insurance. This study of the satisfaction of Insurance beneficiaries gave Insurance a score of 90 (ACSI scores of 90 are excellent) and stated that this is among the very highest ever recorded for either Government or private industry. Insurance also received a score of 90 for reputation, which is an extremely high index for reputation and is in line with the overall satisfaction index. The Insurance Program also was the recipient of the VA's prestigious Robert W. Carey Quality Award in the "Benefits Category" for 2001, for the second year in a row.

The majority (approximately 93%) of the Insurance program's administrative expenses are reimbursed from the Insurance programs. Since 1996, legislation has authorized the payment of Insurance administrative expenses out of excess earnings from the NSLI, VSLI and United States Government Life Insurance (USGLI) programs. Prior to 1996, only three of the eight government life insurance programs (SGLI, VGLI and Veterans Reopened Insurance (VRI)) paid their own costs of administration from premium income and/or fund surplus. This feature was established under each program's originating legislation. Prior to 1996, the cost of administration of the remaining five programs was borne by the Government. Because the program's administrative costs are primarily borne by the policyholder, we make every attempt to keep our expenses low. The Insurance program's administrative costs are significantly lower than comparable commercial insurance company costs. In 2000, the most recent year that data are available, the median cost of administering a policy for commercial insurance companies was $82.75 per policy to perform the functions that were performed by VA at a cost of $17.66 per policy.

Burial – Ensure burial needs are met

In order to achieve the performance goal of increasing the percent of veterans served by a burial option in a national or state veterans cemetery, VA will develop additional national cemeteries in unserved areas; expand existing national cemeteries to continue to provide service to meet projected demand, including the development of columbaria and the acquisition of additional land; and develop alternative burial options consistent with veterans' expectations.

Interment operations began at Fort Sill National Cemetery, near Oklahoma City, Oklahoma, in November 2001, providing service to over 165,000 veterans. A new national cemetery in the area of Atlanta, Georgia, will begin interment operations in 2003. NCA is also planning for the development of new national cemeteries to serve veterans in the areas of Detroit, Michigan; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. When open, these five cemeteries will provide a burial option to nearly two million veterans who are not currently served. These locations were identified in a May 2000 report to

Congress as the six areas most in need of a new national cemetery, based on demographic studies.

VA will expand existing national cemeteries by completing phased development projects in order to make additional gravesites or columbaria available for interments. Phased development in 10-year increments is a part of the routine operation of an open national cemetery. It is the practice of NCA to lay out and subdivide a cemetery by sections or areas so it may be developed sequentially as the need approaches. National cemeteries that will close due to depletion of grave space are identified to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land, or by the construction of columbaria.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery, and the number of additional cemeteries required to meet veterans' burial needs through 2020. The contractor's report will be provided in the winter of 2002.

To achieve our performance goal to increase the percent of veterans served by a burial option, it is also necessary that state veterans cemeteries be established or expanded to complement VA's system of national cemeteries. NCA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries, including the acquisition of initial operating equipment. These cemeteries may be located by the states in areas where there are no plans for VA to operate and maintain a national cemetery. Forty-seven operating state veterans cemeteries have been established, expanded, or improved using the SCGP. By 2003, states will open 8 new state veterans cemeteries that will provide service to over 270,000 veterans not currently served by a burial option.

In meeting the burial needs of veterans and eligible family members, VA will continue to provide high quality, courteous, and responsive service. We will continue to obtain feedback from veterans, their families, and other cemetery visitors to ascertain how they perceive the quality of service provided. Using a customer satisfaction survey, NCA measures its success in delivering service with courtesy, compassion, and respect. We will also continue to conduct focus groups to collect data on stakeholder expectations and their perceptions related to the quality of service provided by national cemeteries. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides us with data from the customer's perspective, which are critical to developing our objectives and associated measures.

To increase awareness of benefits and services provided, NCA conducts outreach and education activities for the veteran community and the general public through the use of news releases, articles appearing in veterans service organization publications, public service announcements, and presentations to schools and community organizations.

To further enhance access to information and improve service to veterans and their families, we will continue to install kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the NCA. By 2003, VA plans to install 48 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve its customers, VA developed three hub cemeteries to provide weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. Each hub cemetery provides this weekend service to families and funeral directors within its geographic area.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet this expectation, VA strives to schedule committal services at national cemeteries within two hours of the request. NCA is evaluating an instrument to collect data for timeliness of scheduling the committal service.

Burial – Timeliness of Marking Graves

NCA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it brings a sense of closure to the grieving process to see the grave marked. Delivery of this benefit is not dependent on interment in a national cemetery.

A data collection instrument, using modern information technology, has been developed to measure the timeliness of marking graves at national cemeteries. NCA is currently collecting baseline data and validating the accuracy and integrity of the data collected. When this review is complete, performance targets will be established.

NCA has also begun to develop the mechanisms necessary to measure the timeliness of providing headstones or markers for the graves of veterans who are not buried in VA national cemeteries. NCA plans to assess data collection

procedures to ensure that data collected to measure timeliness of delivery of headstones and markers are accurate, valid, and verifiable.

The Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, includes a provision that allows VA to furnish an appropriate marker for the graves of eligible veterans buried in private cemeteries, whose deaths occur on or after December 27, 2001, regardless of whether the grave is already marked with a non-government marker. This authority expires on December 31, 2006. However, not later than February 1, 2006, VA shall report the rate of use of this benefit; an assessment as to the extent to which these markers are being delivered to cemeteries and placed on grave sites consistent with the provisions of law; and a recommendation for extension or repeal of the expiration date.

NCA will improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process, the placing of the headstone or marker at the gravesite.

NCA will use, to the maximum extent possible, modern information technology to automate its operational processes. On-line ordering using NCA's Automated Monument Application System – Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors are improvements that increase the efficiency of the headstone and marker ordering process.

NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. In 2001, 34 other federal and state veterans cemeteries ordered headstones and markers online.

Strategic Goal: *Contribute to the public health, emergency preparedness, socio-economic well being and history of the Nation.*

Medical Research

VA complies with the federal regulations system that outlines the responsibilities for protecting human subjects. Investigators continue to be responsible for conducting research, in accordance with regulations. Institutions continue with oversight mechanisms, including local committees known as institutional review boards (IRB). IRBs are responsible for reviewing both research proposals and ongoing research. Agencies like VA are responsible for ensuring that their IRBs comply with applicable regulations, and that they provide sufficient space and staff to accomplish their obligations. VA requires that each VAMC engaged in research with human subjects, establish its own IRB or secure the services of another IRB at an affiliated university. VHA continues to

operate the Office of Research Compliance and Assurance (ORCA), to advise the Under Secretary for Health on all matters relating to the integrity of research protections, to promote the ethical conduct of research, and to investigate allegations of research impropriety.

Within VHA, Networks must comply fully with regulations and demonstrate such compliance in the following ways:

- Via Network Director monitors, each VISN Director is required to submit a quarterly report listing appropriate accreditation agencies for the Network's research programs, including dates of such review and conclusions of those reviews.

- VISN Directors are also required to report whether the Network is scheduled for an NCQA review and supply the dates of such review as well.

- Part of each Network Director's annual performance evaluation is therefore based on completion or outcome of various research compliance measures. This evaluation is based on including all necessary accreditation agencies' full accreditation and clearly defined plans for any new accreditation that is planned.

The FY 2001 performance goal for NCQA accreditation of VA Human Subjects Protection Programs was not achieved due to three intervening and unforeseen circumstances. VHA expects to meet the FY 2002 NCQA target level now that these issues have been resolved. With regard to other performance achievement, all 80 Veterinary Medical Units within the VA Research Program are accredited by the AAALAC (100 percent of goal) and all VA facilities requiring licensure by the Nuclear Regulatory Commission received it. The NRC is required for all facilities that utilize radioactive materials and/or radiation producing devices for research or clinical purposes. Oversight of these licensing activities is the responsibility of VA's National Health Physics Program (NHPP), a component of the Office of Patient Care Services.

Medical Education

VA has established and continues to evaluate responses to its annual survey assessing medical residents' and their trainees' satisfaction ratings of their clinical training experience. VA conducts extensive education and training programs to enhance the quality of care provided to veterans within the VA health care system. Education and training efforts are accomplished through coordinating programs and activities directly related to the education and training of health professions' students and medical residents by partnering with affiliated academic institutions. Veterans directly benefit from the care provided by supervised students and residents because the academic milieu encourages sharing of new information, research results, techniques and treatment modalities. VA's education and training programs also enhance VA's ability to

recruit and retain the best clinical staff. VA can better meet its educational mission because the results of the satisfaction survey identify key drivers of learner satisfaction that lead to continuous quality-focused improvements.

Burial

In order to achieve our objective, NCA must maintain occupied graves and developed acreage in a manner befitting national shrines. Improvements in the appearance of burial grounds and historic structures are necessary for NCA to fulfill this national shrine commitment. In-ground gravesites (casket and cremain) require maintenance to correct ground sinkage and to keep the headstones and markers aligned. Maintenance of columbaria includes cleaning stains from stone surfaces, maintaining the caulking and grouting between the units, and maintaining the surrounding walkways. Cemetery acreage that has been developed into burial areas and other areas that are no longer in a natural state also require regular maintenance.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent study to look at various issues related to the National Shrine Commitment and its focus on cemetery appearance. A study is underway to identify the one-time repairs needed to ensure a dignified and respectful setting appropriate for each national cemetery. Recommendations to address deferred maintenance issues or preventive steps to minimize future maintenance costs will be identified. The study will also include a report on the feasibility of establishing standards of appearance for national cemeteries equal to the finest cemeteries in the world. Varying characteristics of cemeteries, such as cemetery status (open, cremation only, and closed), as well as geographic and climatic conditions, will be taken into consideration. The contractor's report will be provided in the winter of 2002.

In advance of this report, a total of $10 million is included in the budget to address obvious, long-standing, deferred maintenance deficiencies. This funding for the National Shrine Commitment initiative will primarily be used for raising, realigning, and cleaning headstones and markers and for renovating gravesites.

All national cemeteries are important locations for patriotic and commemorative events. NCA will continue to host ceremonies and memorial services at national cemeteries to honor those who made the supreme sacrifice. To preserve our Nation's history, NCA will continue to conduct educational tours and programs for schools and civic groups.

Strategic Goal: *Create an environment that fosters the delivery of One VA world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.*

In FY 2002, the Office of Public Affairs implemented the Department's Communication Plan to effectively build public awareness of, and support for, the mission and programs of the Department. This plan provides the framework within which all VA personnel can effectively communicate key VA messages as an essential part of their mission. VA's communication must bridge internal organizational structures and barriers, as well as send consistent messages through many voices, to internal and external stakeholders, and focus efforts to inform and educate those audiences with messages that help achieve VA goals.

Major Management Challenges

Each year, VA's Office of Inspector General (OIG) and the General Accounting Office (GAO) separately identify what they consider to be the major performance and accountability challenges facing the Department. This section of the Performance Plan presents each of these challenges and outlines what steps VA plans to take to resolve them. The following is an update prepared by VA's OIG summarizing the most serious management problems facing VA, and assessing the Department's progress in addressing these problem areas. Although VA does not have specific quantifiable goals and performance measures for each challenge, the Department does have corrective action plans in various stages of implementation. Where we have performance measures that directly address a challenge, we include the 2003 performance goal. Progress will be monitored until each management challenge has been successfully addressed. (On pages, 162 - 199 the words "we" and "our" refers to the OIG.)

Management Challenges Identified by VA's Office of Inspector General

1. *Health Care Quality Management and Patient Safety*

Challenge Description: Of the many challenges facing VA, one of the most serious, and potentially volatile, is the need to maintain a highly effective health care quality management program. The issues that punctuate the importance of this challenge are VA's need to ensure the high quality of veterans' health care and patient safety, and to demonstrate to Department overseers that VA health care programs are effective.

One example of a particularly difficult and complex undertaking is the need to provide safe, high quality, patient care in an environment that is rapidly evolving from the traditional specialty-based inpatient care to an ambulatory care/outpatient primary care setting. Increasing reliance on treatment in ambulatory care settings can increase opportunities for clinicians to make errors in treating patients and increase the risk of patients receiving uncoordinated care among various outpatient disciplines. While patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety such as missed diagnoses, inappropriate treatments, prescription errors, and failure to follow-up. The health care industry, including the Veterans Health Administration (VHA), needs to identify and correct these kinds of system problems.

A fully functional quality management program should be able to monitor patients' care to ensure their safety and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events, undetected misdiagnoses, failure to treat through uncoordinated care, etc. These types of risk management functions are intended to assure patients that they will be cared for in a manner

that promotes their maximum safety while providing them with optimal medical treatment.

In recent years, VHA has not provided consistent clinical quality management leadership at all levels of the organization. This is due in part to the devolution of management authority from VHA headquarters to the Veterans Integrated Service Network (VISN) and individual VA medical center (VAMC) levels, coupled with resource reductions associated with the Veterans Equitable Resource Allocation model. In 2000, following an OIG review, VHA managers agreed to develop functional descriptions, which would help ensure the consistency of staffing patterns in VAMCs' quality management departments throughout the country. While no two VAMC quality management departments may focus on similar clinical quality issues in the same way, the VHA quality management system may begin to operate in a more consistent manner if the functional guidelines are followed. However, functional and resource disparities continue to impede the Department's ability to identify or measure the extent of possibly widespread unsatisfactory clinical practices, and to devise procedures to correct or eliminate such problems.

VHA's National Center for Patient Safety (NCPS) training on the principles of root-cause analysis, which responded to past OIG recommendations, continues and is well received by VHA employees. NCPS's focus on patient safety and resolving long-standing patient vulnerabilities has helped make VHA medical facilities a safer environment for their patients.

Current Status: Although VHA managers are vigorously addressing the Department's risk management and patient safety procedures in an effort to strengthen patients' confidence while they are under VA care, system issues remain. In addition, concerns exist for the care VA provides veterans in the private sector, e.g., on a contract or fee basis. Patient safety in these settings needs additional quality management attention. For example, patients, their family members, and members of Congress are concerned about patient safety and the quality of care provided in VA contract nursing homes. During our Combined Assessment Program (CAP) reviews[1], we found that VA contract nursing home inspections were not sufficient to ensure that patient safety and quality of care were equal to that provided in VA nursing homes. Also, in January 1994, the OIG issued a report titled *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes* (Report No. 4R3-A28-016) that recommended VHA develop standardized community nursing home inspection procedures and criteria for approving homes for participation in the program. VHA has not implemented the OIG recommendations made in the 1994 OIG

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[1] Through this program, auditors, investigators, and healthcare inspectors collaborate to assess key operations and programs at VA healthcare systems and VA regional offices on a cyclical basis.

report. In addition, the U.S. General Accounting Office (GAO) issued a report in July 2001 that had similar recommendations. We are reviewing the need for additional OIG oversight of VHA's inspections and patient safety measures for veterans' care in contract nursing homes.

VHA is also responsible for overseeing and evaluating care provided to veterans in State veterans homes. In January 1999, the OIG issued a report titled *Evaluation of VHA's State Veterans Home Inspection Process* (Report No. 9HI-A06-014) that indicated State veterans home inspections frequently did not adhere to VHA guidelines because employees did not understand their responsibilities. VHA has not implemented the OIG recommendation that they expeditiously conclude their revision and update of the State veterans home policies and procedures included in the annual inspection guidance issued to VAMCs.

The OIG conducted a nationwide assessment of VHA's policies and practices for evaluating and managing violent and potentially violent psychiatric patients. Our March 1996 report titled *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients* (Report No. 6HI-A28-038) recommended that VHA managers explore network flagging systems that would ensure employees at all VAMCs are alerted when patients who have a history of violence arrive at a medical center for treatment. VHA concurred that VISN-level/national databases are needed to support information sharing; however, this recommendation has not been implemented.

Another key patient safety and quality management concern is that the credentials and background assessment system for all patient care providers VA uses, whether VA-paid or not, is not consistent. This places veterans at risk if they receive care from a VA contract or part-time provider on a fee basis who may have an adverse clinical practice history unknown to VA or the patient. The OIG remains committed to reviewing the issue of credentials of non-VA providers who treat veterans.

The OIG is focusing on other areas of patient care that are vulnerable to system problems. Specifically, in addition to focusing on patient care and safety issues in VHA contract nursing homes, we are focusing on pain management, clinic waiting times, homemaker/home health services, primary care for patients in the area of mental health, VAMC sanitation and cleanliness, and patient satisfaction, as part of our CAP reviews. We are also reviewing quality and access-to-care issues in VHA's community-based outpatient clinics.

Future Plans from VHA Program Offices: VHA continues to make significant, nationally recognized progress in its national patient safety/risk management initiatives. Concerns still exist in oversight of care provided to veterans in contract nursing homes. VHA is currently making final revisions on a comprehensive draft directive, on Community Nursing Home Evaluation and Monitoring. Plans are also underway to establish annual review protocols and

follow-up training for VA staff that conduct nursing home inspections. Progress is also being made in revitalizing the information system that monitors facility compliance with the annual review of community nursing homes. A new report is also being designed to monitor compliance with the monthly visit standard.

VHA continues to finalize action to address on the one remaining OIG recommendation about the State veterans home inspection process, involving revision and update of the policies and procedures included in the annual inspection guidance issued to VAMCs of jurisdiction. Completion of this task involves multiple associated steps. Guidelines for State nursing home care standards have been drafted into a training document. They are being used to "test" the guideline. The directive for the State Nursing Home Care Program will be based on the final State nursing home care regulation and will have to be reviewed and approved by General Counsel. The final directive for every level of care will be held until all regulations (State Nursing Home Care, State Adult Day Health Care, State Home Domiciliary Care, State Home Hospital Care) are final. At this point, finalization dates for these regulations have not been verified.

VHA continues to finalize a computerized advisory directive to reflect the approach that is being taken to initiate a computerized system of flagging repetitively dangerous patients. An initial directive has been reviewed by the General Counsel, and Mental Health program officials and the Office of Information continue with project design. The final product may be available for implementation in June 2002.

VA's system for credentialing health care providers, VetPro, is fully operational, secure and state-of-the-art. VA's Under Secretary for Health recently received the highest Public Health Service's award, the Surgeon General's Medallion, for his leadership in implementing this system. VetPro is an electronic data bank that ensures health care professionals have appropriate degrees and licenses as well as track records of high-quality and safe patient care. Streamlining of the system will continue.

VA is developing new clinic wait time measures to quantify the wait times of new enrollees. VA is also developing a new survey to assess the experiences of new enrollees in requesting appointments. The data from the new measure, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in numbers of new enrollees. VA is also recommending the development of standardized entry process for new enrollees. This process will assist in the automated collection of relevant wait time information at the time that the veteran enrolls in the system.

Performance Goals from VHA Program Offices

1. Improve performance on the Chronic Disease Care Index II to 79 percent.

2. Maintain performance on the Prevention Index II at 80 percent.

3. Ensure all facilities have a contingency plan for the loss of the electronic ability of the Bar Code Medication Administration (BCMA) process.

4. Increase the proportion of inpatients and outpatients rating VA health care service as "very good" or "excellent" to 68 and 69 percent, respectively.

5. Increase the percent of primary care appointments scheduled within 30 days of desired date to 89 percent.

6. Increase the percent of specialist appointments scheduled within 30 days of the desired date to 87 percent.

7. Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 72 percent.

8. Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost value to 102 percent.

2. *Resource Allocation*

Challenge Description: In 1997, Congress required VA to address resource inequities nationwide. Public Law 104-204 mandated that VA develop a plan to improve distribution of resources and ensure veterans equitable access to care across the United States. As a result, VA now uses the Veterans' Equitable Resource Allocation (VERA) system.

Prior to FY 1997, VA used three different resource allocation systems.[2] They were designed to improve certain functions of each preceding funding allocation system. VAMCs received and managed their own budgets, and annual incremental increases were based on prior year allocations. Funds allocated through each of these systems were based on historic funding imbalances that perpetuated inequitable allocations of resources and unequal access to care. The inequities that resulted were caused by a shift in the veteran population demographics without an accompanying shift in resource allocations.

VA developed the current VERA system in response to the legislative mandate and began system implementation in FY 1997. VERA is a capitation-based allocation methodology that moves funds among the VISNs based on patient workload. In FY 2001, $17.7 billion (88 percent of medical care resources) was distributed VISNs using the VERA system. The system provides some

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[2] The other three were: (a) prior to 1985 -- Incremental Funding, (b) 1984-1985 -- Resource Allocation Model, and (c) 1984-1997 -- Resource Planning and Management model.

incentives for achieving cost efficiencies and serving more veterans. VISNs maintain responsibility for allocating resources among the facilities in their prescribed geographic areas.

In 1986, Congress requested that VA develop the Decision Support System (DSS), an automated information system. The purpose of DSS was to provide accurate tracking of resource expenditures on a near real-time basis allowing managers to make more informed and more proactive decisions. Despite the great potential of DSS, VHA has encountered problems implementing and using it in decision-making.

The OIG published a report titled *Audit of Veterans Health Administration Decision Support System Standardization* (Report No. 9R4-A19-075) in March 1999. This report discussed the fact that despite significant expenditures for the development and implementation of DSS, not all VHA facilities implemented and used DSS in the same way. In addition, the report discussed resistance to DSS on the part of many VHA managers. As a result, data was not homogenous across VHA facilities and programs, and DSS could not be used to provide accurate tracking of resource expenditures nor relied upon for decision-making. In March 2001, the OIG closed the DSS report recommendations after VHA published a directive on DSS.

In July 1999, the OIG issued a report titled *Evaluation of VHA Radiology and Nuclear Medicine Activities* (Report No. 9R4-A02-133) that found staffing disparities existed among medical centers with comparable workloads and most Radiology and Nuclear Medicine Services did not apply staffing guidelines, or there was disparity in the guidelines that were used. We recommended that VHA take action to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

The GAO also issued reports in 1997 and 1998 that found responsibility for generating data and reporting results is fragmented in VA's system. VA managers did not have timely, comparable, and comprehensive information needed to monitor changes in access to care. GAO reported that VA headquarters had not provided criteria or guidance for improving the equity of resource allocations to facilities and that VA did not review Network allocation methods or results to determine whether allocations within each Network were made equitably.

Current Status: The OIG is continuing to assess the Department's allocation of resources. Currently, we are reviewing the management of nurse resources to determine if sufficient staffing resources are allocated and properly distributed to provide optimum patient care.

A review of historical VERA allocation data and results of a recent OIG management review in VISN 8 show that there are problems with the way VERA allocates funds. Over the last 5 years, VERA has resulted in the shifting of

significant amounts of resources to VISNs that were previously under-funded, however resource allocation issues remain unresolved. In August 2001, the OIG issued a report titled *Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network 8* (Report No. 99-00057-55). The report recommended that the VERA model include priority group 7 veterans (the majority of whom are currently excluded) so that the total numbers of veterans enrolled and treated are appropriately considered in funding decisions.

Our CAP reviews from 1999 through 2001 also identified uneven implementation levels and inconsistent utilization of DSS. CAP reviews have identified numerous examples where there was a need to realign staffing and resources to correct identified resource deficiencies. We concluded from CAP reviews that VHA needs to more aggressively assess changing health care system resource needs and direct VISN resources to those facilities experiencing shortages.

In July 2001, DSS program officials provided information that showed DSS was 96 percent standardized. However, VHA officials continue to encounter difficulty convincing some facility and VISN managers to incorporate DSS into their management processes. As a result, DSS is still not a completely effective management tool for monitoring and analyzing resource allocation at any level in VHA. We found that some facilities had completely implemented DSS and used it to a pronounced degree in decision-making while other facilities ignored DSS, and management at these facilities believed DSS data was unreliable. As a result, resource allocation is considered a significant management challenge in the Department.

VHA has not implemented the OIG recommendation made in the July 1999 report to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

Future Plan from VHA Program Office: VHA has adequately responded to recommendations in the OIG reports on the Decision Support System and the VERA allocation system (*Availability of Health Care Services in Florida/Puerto Rico, VISN* 8) and no further reporting is required. The report has been closed.

Although the proposed directive on Diagnostic Radiology Staffing has been completed, as well as a handbook on Nuclear Medicine and Radiation Safety, the Office of the Assistant Deputy Under Secretary for Health has recommended disapproval of the staffing directive. Deliberations continue and a final decision on the directive has not yet been made.

3. *Compensation and Pension (C&P) Timeliness, Quality, and Inappropriate Benefit Payments*

Challenge Description: **Timeliness and Quality**

For the past quarter century, the Veterans Benefits Administration (VBA) has struggled with timeliness of claims processing; it continues to face a large backlog and takes an unacceptably long time to process claims. As of September 30, 2001, VBA reported a backlog of more than 532,000 cases. In FY 2001, VBA reported that C&P rating-related actions took an average of 181 days to process.

In December 1997, the OIG issued a report titled *Summary Report on VA Claims Processing Issues* (Report No. 8D2-B01-001) that identified opportunities for improving the timeliness and quality of claims processing and veterans' overall satisfaction with VA claims services. In our September 1998 report titled *Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act* (Report No. 8R5-B01-147) and our October 1998 report titled *Accuracy of Data Used to Measure Claims Processing Timeliness* (Report No. 9R5-B01-005), we reported that three key C&P timeliness measures lacked integrity and that actual timeliness was well above reported timeliness.

Current Status: The Secretary created a new Claims Processing Task Force in May 2001 to propose measures and actions to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the validity and acceptability of decisions. A report on the Task Force's findings and recommendations was issued. Two major types of claims – claims that are older than 1 year and claims that are caught in the appeals-remand cycle – troubled the Task Force. As a result, the Task Force recommended creating a Tiger Team empowered to cut red tape in order to resolve claims affecting aging veterans. This initiative is expected to make a major impact on the most difficult claims and should reduce the average processing time. Until VA can redesign the appeals and remand process, the Task Force also recommended to the Secretary that each VA regional office (VARO) establish, as a priority, a specialized team to manage and process appeals and remand actions locally.

The Task Force reported the appeals process today is ill suited to serve veterans or VA, and made several recommendations targeted at improving the timeliness of appeals processing. These include: (i) establish a special team of experienced VBA staff to expedite resolution of C&P cases over a year old, (ii) require the Board of Veterans Appeals to develop and process the current workload of appeals rather than issuing remands, (iii) establish specialized claims processing teams, (iv) improve record recovery from the VA Records Management Center, and (v) maintain or increase competitive outsourcing of medical examinations. In April 2001, the Secretary also directed the Board of

Veterans Appeals to reduce the time veterans have to wait for appellate decisions. VA needs a better system to manage appeals.

Additional actions taken to improve claims processing timeliness include the development of compensation program outcome statements that reflect the views of key stakeholders. Efforts are currently under way to develop outcome performance measures that support each of the outcome statements. Similar efforts are underway for the pension program. New initiatives for FY 2002 include: development of an on-line application system for C&P benefit; expansion of claims development efforts for service persons awaiting discharge; development of the Personnel Information Exchange System to include all military records centers; implementation of paperless technologies to allow the processing of claims in a fully electronic environment; centralized C&P training programs; and changes to regulations to permit oral evidence gathering. Actions are also underway to improve the ongoing quality, timeliness, and cost of VHA C&P medical examinations.

Current Status: The OIG plans to continue conducting CAP reviews at VAROs and plans to summarize program findings in FY 2002.

Future Plans from VBA Program Offices: The Secretary of Veterans Affairs has set a goal of monthly average of 100 days to process rating-related claims during the last quarter of FY 2003, while continuing to improve quality. VA is putting in place several mitigation actions that cumulatively will dramatically improve timeliness by the end of 2003. As an early step, the Department has launched a major effort to resolve 81,000 of our oldest claims, ones that have been pending more than one year. A special team has been established at the Cleveland Regional Office to tackle many of these oldest claims, especially those claims from veterans over age 70.

VA reduced the appeals resolution time by 5 percent during 2001. We will continue to work toward additional reductions in the length of time required to process appeals of claims by reducing the remand rate.

VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify the tools and procedures needed to improve the quality and timeliness of C&P medical examinations. It is currently functioning and recruitment is underway for all the necessary subject matter experts from both VBA and VHA.

Challenge Description: **Inappropriate Benefit Payments**

VBA needs to develop and implement an effective method to identify inappropriate benefit payments. Recent OIG audits found that the appropriateness of VBA payments has not been adequately addressed.

Payments to Incarcerated Veterans

In February 1999, the OIG published a report titled *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans, and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in six states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustments, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid about $100 million. Additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents, if VBA does not establish a systematic method to identify these incarcerated veterans.

Our July 1986 report titled *Benefit Payments to Incarcerated Veterans* (Report No. 6R3-B01-110) found that controls were not in place to cut off benefits to veterans when they were incarcerated. That report recommended that a systematic approach be applied; however, actions were not taken to implement the recommendations in the 1986 report.

Current Status: VBA has implemented 1 of 4 recommendations from the February 1999 OIG report. The recommendations that VBA: (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure VAROs process identified cases timely, and properly adjust benefits, are unimplemented.

Future Plans from VBA Program Office: VA signed a Memorandum of Understanding with the Social Security Administration (SSA) that will allow us to receive their state and local prisoner files for a matching program. Once the data exchange from SSA is secured, the existing procedures used for the Federal Bureau of Prisons (FBOP) will apply. The system to identify and adjust benefits will be identical to the existing system used for FBOP. Both the FBOP and SSA prison matches will continue as ongoing processes.

Benefit Overpayments Due to Unreported Beneficiary Income

VBA's Income Verification Match (IVM) did not effectively result in required benefit payment adjustments and identification of program fraud, thus IVM remains a significant internal control and financial risk area. Our November 2000 report titled *Audit of Veterans Benefits Administration's Income Verification Match Results* (Report No. 99-00059-1) found that opportunities exist for VBA to: (i) significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered, (ii) better ensure program integrity and

identification of program fraud, and (iii) improve delivery of services to beneficiaries.

The audit reported that the potential monetary impact of the OIG findings to the Department was $806 million. Of this amount, we estimated potential overpayments of $773 million associated with benefit claims that contained fraud indicators such as fictitious Social Security numbers, or some other inaccurate key data elements. The remaining $33 million was related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimated that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

Current Status: VBA has implemented 7 of 8 recommendations from the November 2000 OIG report. The recommendation to complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA remains unimplemented. This recommendation was a repeat recommendation from our 1990 OIG report.

Future Plans from VBA Program Office: VBA agreed to implement the following recommendations: (i) increase program oversight of the results of IVM actions completed; (ii) eliminate the review of selected pension cases because they result in no benefit overpayment recoveries; (iii) eliminate review of IVM cases with income discrepancy amounts of less than $500 because they result in little or no benefit overpayment recoveries; (iv) complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA; (v) ensure that accounts receivable are established to recover IVM-related debts from beneficiaries; (vi) ensure that waivers of beneficiary IVM-related debts are not granted when fraud is identified; (vii) refer potential fraud cases to the OIG based on the established referral process; (viii) report the IVM for consideration as an Internal High Priority Area that needs monitoring.

Disability Compensation Benefits for Active Military Reservists

In May 1997, the OIG conducted a review to determine whether VBA procedures ensure that disability compensation benefits paid to active military reservists are offset from training and drill pay as required by law. The OIG report titled *Review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation* (Report No. 7R1-B01-089) identified that VBA had not offset VA disability compensation to 90 percent of the sampled active military reservists receiving military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and 1995 and, if the condition was not corrected, annual dual compensation payments, estimated at $8 million, would continue to be made. Dual payments occurred because procedures established between VA and the Department of Defense (DoD) were not effective or were not fully implemented.

Current Status: VBA has not implemented the recommendation to follow up on FY 1993-1996 dual compensation cases to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservists' pay.

Future Plans from VBA Program Office: VA has been coordinating the receipt of drill pay information with the Defense Manpower Data Center (DMDC) since late 1999. However, the information received by VA was found to be inaccurate. DMDC and DFAS worked together to identify the problems in their reporting. In June of 2001, DMDC indicated that they had been successful in identifying and correcting the errors, however, they cannot provide accurate data on drill days prior to FY 2001. We expect to begin the matching program again using the FY 2001 information during FY 2002.

Benefit Overpayment Risks Due to Internal Control Weaknesses

In FY 1999, the Under Secretary for Benefits asked for OIG assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled over $1 million by exploiting internal control weaknesses in the C&P program. Our vulnerability assessment identified 18 categories of vulnerability involving numerous technical, procedural, and policy issues. The Under Secretary for Benefits agreed to initiate actions to address the weaknesses identified.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. That VARO was selected for review because it was one of the Department's largest VAROs, accounting for 6 percent of C&P workload and was the location where 2 of 3 known frauds took place. The July 2000 report titled *Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office St. Petersburg, FL* (Report No. 99-00169-97) confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the VARO.

Current Status: There is an ongoing criminal investigation at the VARO in Atlanta, GA, where an estimated $11 million in fraudulent benefits were processed. At the request of the Secretary, the IG agreed to conduct a review of all one-time C&P payments, valued at $25,000 or more, made since 1995, to determine if the payments were valid. The OIG will also conduct CAP reviews at selected VAROs to assess internal control weaknesses previously identified in our vulnerability assessment along with reviewing other related claims processing issues.

VBA agreed to address the 18 internal control weaknesses identified in the vulnerability assessment and the 15 recommendations identified in the St. Petersburg audit. Implementation action on these recommendations is currently in process.

Future Plans from VBA Program Office: VBA agreed to address the internal control weaknesses identified in the vulnerability assessment and the 15 recommendations included in the St. Petersburg regional office audit. Implementation action on these recommendations is currently in process.

Example Performance Goals from VBA Program Offices:

1. Complete rating-related actions on compensation and pension claims in an average of 165 days. (*This number is the average cumulative for the fiscal year. We expect to achieve 100 days processing time during the last quarter.*)

2. Attain an 88 percent national accuracy rate for core rating work.

3. Reduce the appeals resolution time to 520 days.

4. Reduce dollar value of overpayments to $290 million.

4. *Government Performance and Results Act (GPRA) - Data Validity*

Challenge Description: Successful implementation of GPRA, including performance-based budgeting, requires that information be accurate and complete. At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. The OIG has completed work on the following six performance measures:[3]

- Average days to complete original disability compensation claims – 34 percent of the records reviewed contained inaccurate or misleading data.

- Average days to complete original disability pension claims – 32 percent of the records reviewed contained inaccurate or misleading data.

- Average days to complete reopened compensation claims – This number of reopened claims was inflated by 18 percent. Of the records reviewed, 53 percent contained inaccurate or misleading data.

- Percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence – VA could not recreate population projections used to calculate this measurement because essential data no longer existed.

- Foreclosure avoidance through servicing ratio – The OIG was unable to attest to the accuracy of the reported ratio because VBA did not maintain necessary documentation.

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[3] The three claims processing timeliness measures we audited have now been incorporated into a new key measure called average days to process rating-related actions.

- Unique Patients – VHA overstated the number of unique patients by 7 percent.

Deficiencies were identified in each performance measure audited. VBA and VHA are taking action to correct the deficiencies.

VA has made progress in implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and Department wide weaknesses in information system security limit our confidence in the quality of data output.

Current Status: The Office of the Assistant Secretary for Management has identified the following management challenges to the successful implementation of GPRA.

- Better alignment of budget accounts with GPRA programs.

- Improvement of financial management systems report structure and timeliness.

- Improvement of cross-cutting activities between VA and DoD.

Audits of three key performance measures -- the VHA prevention index, the VHA chronic disease care index, and the accuracy of the VBA veteran rehabilitation rate -- are in process.

Future Plans provided by VA Program Offices: To date, the OIG has completed audits of six key measures, with several others on the agenda for the near-term. VBA and VHA began taking action to correct the deficiencies identified in the data for which they have responsibility. Specifically in regard to a VHA issue, the Austin Automation Center installed corrective edit checks in the reporting of unique patients to assure full accuracy, and OIG closed the report. Also, edits of the VHA prevention index and chronic dieses care index are in process. Inconsistencies identified in NCA's estimate of the percent of the veteran population served by a burial option within a reasonable distance of place of residence have been corrected.

VA has made progress in implementing GPRA, although additional improvement is needed to ensure stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation.

For additional information on data quality, see the Assessment of Data Quality section. Specific methods of validating data for each of the Department's key performance measures are included in the key policy issue discussions.

5. *Security of Systems and Data*

Challenge Description: VA faces significant challenges in addressing Federal information security program requirements and establishing a comprehensive integrated VA security program while homeland security risks continue to escalate. Information security is critical to ensure the confidentially, integrity, and availability of VA data and the assets required to support the delivery of health care and benefits to the Nation's veterans. VA provides medical services at over 1,150 sites, a benefits delivery network of 57 VAROs, a burial system involving 119 national cemeteries, maintains 3 major data processing centers, and provides other Departmental functions. VA is highly dependent on automated information systems to support its mission to deliver services to our Nation's veterans.

The three VA administrations' stovepipe operations have not adopted standard hardware and software integration, which contributes to security vulnerabilities in the Department. Decentralization of information technology and lack of management oversight at all levels have also contributed to inefficient practices and to weaknesses in safeguarding electronic information and physical security of assets.

Previous OIG audit reports have identified weaknesses in information security throughout VA. With passage of the Government Information Security Reform Act (GISRA) as part of the FY 2000 Defense Authorization bill, the OIG is required to complete an independent assessment of VA's compliance with the Act. Limited information had been developed by VA on existing information security vulnerabilities that could be analyzed to establish a baseline on the adequacy of VA's information security. Therefore, the OIG performed vulnerability assessments and penetration tests of selected segments of the Department's electronic network of operations to identify vulnerabilities that place sensitive data at risk of unauthorized disclosure and use.

Current Status: Our October 2001 report titled *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 00-02797-001) found that weaknesses exist, and as a result, require the continuing designation of information security as a Department material weakness area under the Federal Managers' Financial Integrity Act. VA systems continue to be vulnerable to unauthorized access and misuse of sensitive automated information and data. The Department has started efforts to correct these weaknesses and work toward compliance with the GISRA requirements; however, results of the recently

completed GISRA audit identified significant information security vulnerabilities that continue to place the Department at risk of:

- Denial of service attacks on mission critical systems.

- Disruption of mission critical systems.

- Unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data.

   In addition, the following key issues were identified:

- VA has established comprehensive information security policies, procedures, and guidelines, but implementation and compliance have been inconsistent.

- VA has been slow to implement a risk management framework. As a result, VA does not comply with GISRA; Office of Management and Budget (OMB) Circular A-130, Appendix III; and Presidential Decision Directive 63 security requirements.

- Penetration tests verified that VA systems could be exploited to gain access to sensitive veteran benefit and health care information.

Results of our February 2001 consolidated financial statements audit have also continued to identify information security weakness. This report titled *Audit of the Department of Veterans Affairs Consolidated Financial Statements For Fiscal Years 2000 and 1999* (Report No. 00-01702-50) found management oversight and control weaknesses continue to be problems in the security of sensitive information. The newly confirmed Chief Information Officer/Assistant Secretary for Information and Technology has taken an aggressive approach to correcting identified weaknesses and hardening the security of the Department's electronic information.

Future Plans from VA Program Offices: The OIG continued its assessment of ADP controls as part of its audit of VA's 2001 Consolidated Financial Statements. In addition, the OIG recently concluded a nationwide audit of VA's Information Security Program to assess VA's efforts to address information security control weaknesses and establish a comprehensive integrated security management program. The actions necessary to reduce risk to an acceptable level require a long-term, sustained effort. To address the VA-wide ADP security and control issues, VA established a centrally managed security group in 1999 and an information security working group, in which the OIG participates. In October 2000, the Department issued a revised Information Security Management Plan that identified a number of security enhancement actions that are being accelerated to improve enterprise-wide information security. VA's Information Security Budget Program identifies 10 areas that VA plans to address during fiscal years 2000-2005, at an estimated cost of over $114 million.

6. *Federal Financial Management Improvement Act and VA's Consolidated Financial Statements (OF, OI&T)*

Challenge Description: The Chief Financial Officers Act of 1990, Government Management Reform Act (GMRA) of 1994, and implementing OMB Bulletins require that VA's consolidated financial statements (CFS) be audited annually by the OIG or the OIG's representative. The agency CFS and related audit reports are integral to the Government wide CFS prepared by the Department of Treasury and audited by the GAO. VA's FY 2000 CFS reported assets totaling $44 billion, liabilities totaling $576 billion, and net operating costs of $45 billion.

VA achieved unqualified CFS audit opinions in FY 2000 and FY 1999. VA has also demonstrated management commitment to addressing material internal control weaknesses previously reported and made significant improvements in financial management. However, remaining material weaknesses are still considered significant, such as noncompliance with the Federal financial management system requirements of the Federal Financial Management Improvement Act. Corrective actions needed to address noncompliance with system requirements are expected to take several years to complete. The OIG also reported other significant conditions addressing the need for improving application programming and operating system change controls, business continuity and disaster recovery planning, and operational oversight.

Current Status:

Integrated Financial Management System Material Weakness

The material weakness concerning the Department's financial management systems underscores the importance that the Department continue its efforts to acquire and implement a replacement integrated core financial management system. However, achieving the success of an unqualified opinion currently requires a number of manual compilations and extraneous processes that the financial management system should perform. These processes require extraordinary administrative efforts by Department program, financial management, and audit staff. As a result, the risk of materially misstating financial information is high, considering the need to perform extensive manual compilations and extraneous processes. Efforts are still needed to ensure adequate accountability, and reliable, useful, and timely information needs to be available to help Department officials make well-informed decisions and judgments.

The February 2001 OIG CFS report noted continuing difficulties related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of the VA's CFS. Examples cited by the CFS auditors include:

- General ledgers for some smaller funds are maintained outside the existing core financial management system.

- Unreconciled differences between the general ledgers and the Property Management System subsidiary ledger exist.

- A significant number of manual adjustments were used during the year-end closing process.

Information Technology Security Controls Material Weakness

The OIG reported this condition in the CFS reports for FY 1997, 1998, and 1999 and made recommendations for VA to implement a comprehensive security program that would improve these controls. The CFS auditors noted the following information technology weaknesses:

- Inadequate security plans and security administration.

- Improper access by programming staff.

- Inappropriate access capabilities by application programmers.

- Inadequate review, investigation, and documentation of network access exceptions.

- Physical access to computer rooms storing production hardware by individuals with incompatible duties.

- Inconsistent anti-virus software upgrades at all locations and improper setup to alert administrators to take prompt actions.

The size of VA programs and the large number of systems that generate program and financial information make correction of existing material weaknesses very complex. VA is also dependent on the receipt of funding through OMB and Congress to implement corrective actions. The target date for completing corrective actions on the information technology security control weaknesses is FY 2003 and corrective action on financial management system deficiencies is FY 2004, when implementation of VA's core Financial and Logistics System (coreFLS) project is scheduled for completion.

Future Plans provided by VA Program Offices: The Department is implementing corrective action plans to correct the material internal control weaknesses. VA's leadership team has initiated cross Administration funding and established individual and collective cyber security responsibility and accountability. A new Office of Cyber Security will implement and monitor the correction of this material internal control weakness. In addition, VBA is correcting three noted items in the Housing Credit Assistance accounting program as well as completing crosswalks to the Department's core accounting system.

Performance Goal from VA Program Offices:

Maintain performance of no audit qualifications identified in auditor's opinion on VA's Consolidated Financial Statements.

7. *Debt Management (VBA, VHA, OF)*

Challenge Description: As of March 2001, debts owed to VA totaled over $4 billion. Debts result from home loan guaranties, direct home loans, life insurance loans, medical care cost fund receivables, compensation, pension, and educational benefits overpayments. Over the last 4 years, the OIG has issued reports addressing the Department's debt management activities. We reported that the Department should be more aggressive in collecting debts, improve debt avoidance practices, and streamline and enhance credit management and debt establishment procedures. VA has addressed many of the concerns reported over the last few years. However, our most recent national and CFS audits and CAP reviews continue to identify debt management issues.

There has been a great deal of dialog and sharing of information between the OIG and VA management to assess the current magnitude of the debt management issues. For example, VBA direct home loans is considered a lender of last resort. Consequently, if a borrower defaults on a loan, few resources are available for VA to collect. However, we feel there are other debt management issues that VA can improve. Issues identified by the OIG relate to: accounts receivable follow-up, timely reconciliation, and billing process problems.

In March 1999, we conducted an evaluation of VHA's IVM program to: (i) follow up on the implementation of recommendations made in a March 1996 OIG report, and (ii) determine whether there were opportunities for VHA to conduct the IVM program in a more efficient and cost effective manner. The OIG report titled *Evaluation of VHA's Income Verification Match Program* (Report No. 9R1-G01-054) found that VHA could increase opportunities to enhance Medical Care Cost Fund (MCCF) collections by $14 million, and put resources valued at $4 million to better use, by requiring VISN directors to establish performance monitors for means testing activities and billing and collection of program referrals. Additionally, to further ensure these monetary benefits are achieved, VHA management needed to implement previous recommendations and the VHA Chief Information Officer needed to increase oversight of the Health Eligibility Center (HEC) activities. VHA also needed to expedite action to centralize means testing activities at the HEC.

Current Status: The Department has performed considerable work in the area of the debt referral process with the Department of Treasury. VA has reported it has met or exceeded Department of Treasury goals this year

demonstrating a commitment to improving debt management within the Department.

VHA has not implemented 7 of 13 recommendations from the March 1999 OIG report on VHA's IVM program.

The OIG is currently conducting an audit to determine VHA's success with MCCF and to identify opportunities to enhance MCCF recoveries. Preliminary audit results show that previous reported conditions, including missed billing opportunities, billing backlogs, and minimal follow up on accounts receivable, are still continuing. Also, insurance identification procedures need improvement. Our July 1998 audit found MCCF recoveries could be increased significantly by more actively managing MCCF program activities; however, our follow-up indicates the recommendations were not effectively implemented.

Future Plans from VA Program Offices: VA staff offices and administrations have been working to reduce the number of outstanding debts. During FY 2001, the Department began an analysis of OIG audits performed over the last 5 years pertaining to debt management. As shown below the audit coverage focused on ten categories in three primary areas.

Medical Care Debts

- Billing and collection of medical care co-payments
- Follow-up on outstanding receivables
- Billing procedures
- Monthly reconciliations

In terms of MCCF activities, VHA's revenue office continues to spend considerable time and effort in identifying opportunities to improve the revenue process. The Revenue Improvement Plan (addressing MCCF issues), completed in September 2001, is a comprehensive document that addresses all aspects of the revenue cycle. It includes an overall improvement plan, responsibilities and time frames for completion. All of the recommendations identified by the OIG are addressed in the plan, as are recommendations that were made by reviews conducted by the Financial and Systems Quality Assurance Service (FSQAS). The plan is now under review in the Office of the Secretary.

Income Verification Process

- Increase program oversight
- Eliminate review of selected pension cases with income discrepancies of less than $500
- Assure that waivers of IVM related debts are not granted in fraud cases

- Data verification of beneficiary identifier number to reduce numbers of unmatched

VHA continues to implement the outstanding recommendations from the report on the Income Verification Match program. The Health Eligibility Center (HEC) has established mechanisms to ensure that IVM conversation cases are referred to all sites of care for appropriate billing action. HEC is working with the VISNs to establish performance standards that require staff involved in the means test co-payment billing process to administer IVM referral cases in a timely manner. HEC also has reporting capabilities that will enable staff at the medical facilities and Networks to monitor and track billing and collection activities. A directive is being prepared for distribution to the Networks and facilities that describes the restart of the IVM process, the new reporting procedures, and draft performance standards for field staff involved in revenue activities related to IVM means test co-payment billing. Target date to resume income verification is April 2002. Redesign of the HEC database and implementation of a national Centralized Renewal of Means Test continue to be on an expedited schedule, and are on target for completion by October 2002.

Compensation and Pension (C&P) Program

- Benefit payment errors

- Weak internal controls

Compliance audits will be performed to ensure that corrective action has been fully implemented to address the deficiencies identified above.

As of June 30, 2001, VA referred 93 percent of eligible debt to the Department of the Treasury's Offset Program (TOP). This is 3 percent above Treasury's goal.

After reaching an agreement with Treasury, VA began referring debts for cross servicing in the first quarter of FY 2001. VA referrals to Treasury have been limited to groups of 5,000 accounts per submission due to Treasury's systems limitations. As of June 30, 2001, VA referred 87 percent of eligible debt to Treasury for cross servicing. Over 90 percent of eligible debt will be referred by the end of FY 2001 once all referrals are completed.

8. Workers' Compensation Costs

Challenge Description: The Federal Employees' Compensation Act (FECA) authorizes benefit payments to civilian employees of the Federal government for disabilities or deaths resulting from injuries or disease sustained in the performance of their official duties. The benefit payments have two components – salary compensation payments and medical treatment payments for specific disabilities. Benefit payments under FECA are made from the Employees'

Compensation Fund administered by the Department of Labor, Office of Workers' Compensation Program (OWCP).

During the period July 1998 through June 1999, VA's OWCP costs totaled over $137 million for the 15,287 active cases. Wage loss compensation was over $106 million (77 percent) and medical costs were over $31 million (23 percent). VHA accounts for about 95 percent of VA's total OWCP cases and costs.

In 1999, we completed a follow-on audit of high-risk areas in the VHA's Workers' Compensation Program (WCP). The audit found that VHA was vulnerable to abuse, fraud, and unnecessary costs associated with WCP claims in three high-risk areas reviewed dual VA benefits, non-VHA employees, and deceased WCP claimants. We estimated that VHA has incurred or will incur about $11 million in unnecessary costs associated with WCP claims in these high-risk areas.

Current Status: The OIG continues to provide technical support and assistance to the Department in their efforts to reduce WCP costs and identify WCP fraud. The OIG identified 82 claims during its FY 99 audit titled *Audit of High-Risk Areas in the Veterans Health Administration's Workers Compensation Program* (Report No. 99-00046-16) that involved potential WCP fraud. Efforts to continue identifying potential program fraud were addressed when the OIG provided two training sessions prior to VHA's one-time review of priority cases identified by automated analysis of VHA's active/open WCP cases. While VHA's reviews did identify cases they believed to be potential fraud, no investigations have been opened on these cases because additional documentation and evidence was needed. The OIG staff discussed these cases with VHA staff; however VHA has not provided the additional information requested.

Additionally, a VA OIG WCP resources Web page (www.va.gov/oig/52/wcp/wcp.htm) was created to allow VA employees to easily find and download WCP products. This Web page contains presentations, reports, and other WCP products, such as the fraud awareness bulletin. It also contains links to VA OIG Office of Investigation press releases on WCP cases.

Future Plans from VA Program Offices: VHA participates actively in the WCP fraud prevention program, and routinely reports cases of potential abuse. Approximately 40-50 cases have already been referred, although it is recognized that not all have met OIG's criteria for actual fraud. We therefore do not agree with OIG's statement that no potential WCP fraud cases have been referred.

9. *Procurement Practices (OA&MM, VHA)*

Challenge Description: The Department spends over $5.1 billion annually for supplies, services, construction, and equipment. VA faces major challenges to

implement a more efficient, effective and coordinated effort that can better ensure the Department's acquisition and delivery efforts to acquire goods and services. A more integrated effort is needed to ensure the benefits of acquiring goods and services outweigh costs. High-level monitoring and oversight need to be recognized as a Department priority, and efforts must continue to maximize the benefits of competition and leverage VA's full buying power. VA must also ensure that adequate levels of medical supplies, equipment, pharmaceuticals, and other supply inventories are on hand to satisfy demand. Inventories above those levels should be avoided so funds that could be used to meet other needs are not tied up in excess inventories.

Historically, procurement actions are at high risk for fraud, waste, abuse, and mismanagement. Vulnerabilities and business losses associated with theft, waste and damage of information technology are known to be significant. Past audits support the need to provide for adequate acquisition planning on a corporate basis and to improve and coordinate national and regional acquisition planning efforts.

Current Status: Recent OIG reviews have identified serious problems with the Department's contracting practices and acquisitions. These reviews have identified the need to improve the Department's procurement practices in areas of acquisition training and oversight, and to better ensure the adequacy and competency of the acquisition workforce. Recent business reviews conducted by the VA Office of Acquisition and Materiel Management (OA&MM) and other audits conducted by the OIG at VA facilities have identified significant problems relating to acquisition planning, training, inventory management, management oversight and contract administration.

The OIG is working with VA and VHA logistics staff to improve procurement practices within the Department. The OIG continues to perform contract audit and drug pricing reviews to detect defective and excessive pricing, and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations. VHA has made the development of an Advanced Acquisition Plan a priority.

An OA&MM Task Group was charged with developing an inventory of procurement problems in December 2000. The Group identified problems with noncompliance with acquisition regulations and poor contract administration on individual procurements as being caused by the failure to hire competent procurements officials, inadequate training, undue pressure, and weak or inconsistent procurement policies. Inadequate or non-existent acquisition planning at the local, VISN, and national levels was also identified. The Group provided a number of recommendations to address these problems effectively.

The Group recommended actions that should improve planning, coordination, and accountability at all Department levels.

Also, the OA&MM Group identified continuing problems with inventory management, purchase cards, scarce medical specialist/sharing contracts and information technology purchases as areas needing immediate study and attention. The group suggests that subgroups consisting of representatives of VHA, OA&MM, OIG and other appropriate offices be formed to address these issues. Subgroups are currently working on addressing specific issues.

Future Plans from VA Program Offices: In November 2000, at the request of the Deputy Under Secretary for Health and the Principal Deputy Assistant Secretary for Management, an Acquisition Issues Task Group prepared a detailed analysis of procurement problems in VHA. The IG served as a member of this group. Some recommendations of this group have been completed or partially completed. Others have been put on hold pending the outcome of the Secretary's Procurement Reform Work Group. This work group was formed in July 2001 and was tasked to look into similar procurement issues. This group is about to turn in its final report to the Secretary. Once the recommendations of both Task Groups have been fully implemented, there should be a marked decrease in procurement related problems.

Federal Supply Schedule Purchases

Federal Supply Schedule (FSS) contracts are awarded non-competitively by the National Acquisition Center to multiple vendors for like or similar commercial off-the-shelf products. The Government's negotiation strategy has historically been to obtain most favored customer pricing or better. Since 1993, the OIG has conducted pre-award and post-award reviews to provide contracting officials with insight into each vendor's commercial sales and marketing practices as well as buying practices. These reviews provide contracting officers with information needed to strengthen the Government's pricing position during negotiations. During the past few years, the effectiveness and integrity of the FSS program have deteriorated because FSS is no longer a mandatory source for these commercial products.

As a result of making FSS contracts non-mandatory sources of supply, there has been an increase in open-market purchases by VAMCs, often without attempts by them to either negotiate prices or determine price reasonableness. The term open-market describes the purchase of goods and services that are not on contract. In increasing numbers, vendors have: (i) withdrawn high-volume medical supply items from FSS contracts, (ii) refused to negotiate in good faith, (iii) cancelled contracts, or (iv) not submitted proposals for FSS contracts.

Although these vendors no longer have contracts, they have not lost their VA market share. They continue to sell in large volumes to individual VAMCs and avoid offering most favored customer prices, shielding themselves from pre-and

post-award reviews. In addition, they are able to sell products made in non-designated countries directly to VA facilities that they cannot sell on FSS or other contracts because of the Buy America and Trade Agreements Act requirements. Previous OIG investigations have resulted in $8 million in civil penalties being imposed on violators of the Act.

Current Status: The OIG CAP reviews at VAMCs have identified non-competitive open-market purchases at significantly higher prices than comparable items offered on FSS contracts. Our reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Many proposals are not being audited as required and may not be receiving legal and technical reviews as required. Management attention is needed to develop clear and useful policies that will ensure fair and reasonable prices, consistency in the use of VA's statutory authority, and proper oversight of such activities.

Inventory Management

The OIG conducted a series of four audits to assess inventory management practices for various categories of supplies. These audits found that excessive inventories were being maintained, unnecessary large quantity purchases are occurring, inventory security and storage deficiencies exist, and controls and accountability over inventories need improvement. A FY 1998 audit of medical supply inventories at five VAMCs found that at any given time the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. A FY 1999 audit of pharmaceutical inventories at four VAMCs found that about 48 percent of the $2 million inventory was in excess of current operating needs. Another audit in FY 2000 at five VAMCs concluded that 47 percent of the $3 million prosthetic supply inventory was excessive.

The main cause of the excess inventories was that the Generic Inventory Package was not being used or was insufficiently used to manage the inventories. VAMCs relied on informal inventory methods and cushions of excess stock as a substitute for the more structured Generic Inventory Package inventory management system. The successful transition to prime vendor distribution programs for pharmaceuticals and other supplies has helped reduce pharmacy inventories from previous levels. However, inventories continue to exceed current operating needs for pharmaceuticals and many other items.

Current Status: The last of the four OIG audits completed in FY 2001 concluded that 67 percent of the $5 million engineering supply inventory at five VAMCs was excessive. At any given time, the estimated value of the four types of inventories was about $435 million.

CAP reviews continue to identify numerous inventory management problems. In addition, problems associated with prime vendor programs have

identified areas where supplies are being acquired at increased costs and/or waste has occurred.

Future Plans from VHA Program Offices: All inventory management problems noted by the IG are addressed in VHA Handbook 1761.2, issued in October 2000. Implementation of the handbook has been delayed because the National Labor Management Organizations (AFGE and NAGE) have requested a national demand to bargain. In August 2001, VA Central Office signed an understanding with AFGE, effectively allowing all AFGE facilities to proceed with implementation of the handbook. However, discussions are still being conducted with NAGE.

Government Purchase Card Use

OIG audits and reviews at selected VAMCs have identified significant vulnerabilities in the use of Government purchase cards. Purchases have been split to circumvent competition requirements and some goods and services have been acquired at excessive prices and without regard to actual needs. Our reviews of purchase card records, invoices, purchase orders, procurement history files and other related records, also lead us to believe that VHA is purchasing open-market health care items in amounts greater than the 20 percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A).

Current Status: Of 33 CAP reports issued from March 31, 1999 to April 11, 2001, 22 identified Government purchase card problems such as the lack of timely reconciliations and certifications, inappropriate approving officials, improper purchases, exceeded purchasing limits, and poor internal controls. These conditions are a result of the widespread and essentially unmonitored use of Government purchase cards in conjunction with the decentralization of purchasing authority to VAMCs. If uncontrolled, risk will escalate as purchase card use increases throughout the Department.

Future Plans of VHA Program Offices: The Office of the Chief Financial Officer is finalizing corrective actions pertaining to VHA on the one remaining OIG recommendation: Strengthen controls over the Purchase Card Program by establishing appropriate mechanisms to monitor unreconciled transactions on a VA-wide basis. VHA requirements have been provided to the coreFLS analysts and the contractor, KPMG Consulting, to ensure the new system can provide the reports. It is expected that all required reports will be available by the time the Department begins nationwide implementation scheduled for April 2003. OIG will close the recommendation when further validation of these actions is received from the contractor. This response is currently being solicited by VHA.

Scarce Medical Specialist Contracts

OIG reviews of scarce medical specialist contracts have identified serious concerns about whether contracts are necessary and costs are fair and reasonable.

Reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Most importantly, the requirement that noncompetitive contracts must be based on cost or pricing data was not enforced. Consequently, VAMCs paid excessive charges on certain contracts. VHA issued guidance and provided training that significantly improved contracting practices. However, we have found that VAMCs have been inappropriately using Intergovernmental Personnel Act assignments and commercial items contracts as a substitute for scarce medical specialist contracts. Use of these purchasing methods, in lieu of contracts, has resulted in higher prices being paid for services than would have been paid using properly negotiated contracts. Management needs to improve oversight to ensure that, when applicable, properly negotiated contracts are used. Furthermore, management needs to develop and/or enforce policies that ensure consistent compliance with VA's statutory authority in order to obtain reasonable prices.

Current Status: During FY 2001, we completed contract reviews of seven health care resource contract proposals involving scarce medical specialists' services. We concluded the contracting officer should negotiate reductions of over $2million to the proposed contract costs.

Future Program Plans for VHA Program Offices: Many of the problems with awarding Scarce Medical Specialist contracts are the result of such contracts being awarded under 38 USC 8183, Enhanced Sharing. Current policy for enhanced sharing does not fully describe how to negotiate and administer these contracts. Previous Scarce Medical Specialist contracting policy was covered in VHA Directive 96-039, which expired in May 2001. A subgroup of the Acquisition Issues Task Group is working on reissuing this directive and providing additional relevant information to help facilities avoid improperly awarding Scarce Medical Specialist contracts.

Controls Over the Fee-Basis Program

We conducted an audit to determine if VHA had established effective internal controls to ensure that payments for fee-basis treatment were appropriate. Fee-basis treatment is inpatient care, outpatient care, or home health care received from non-VA health care providers at VA expense. In June 1997, the OIG issued a report titled *Audit of Internal Controls over the Fee-Basis Program* (Report No. 7R3-A05-099) that found VHA could reduce fee-basis home health care expenditures by at least $1.8 million annually and improve the cost effectiveness of home health services by: (i) establishing guidelines for contracting for such services, and (ii) providing contracting officers with benchmark rates for determining the reasonableness of charges.

Current Status: VHA has not implemented the OIG recommendations in the June 1997 report to establish guidelines for contracting and provide contracting officers with benchmark rates.

Future Plans from VHA Program Offices: VHA has implemented all but one of the recommendations from the June 1997 report. The remaining recommendation deals with establishing guidelines for contracting home health services and providing contracting officers with benchmark rates for determining the reasonableness of charges. VHA's Geriatrics and Extended Care Strategic Health Care Group is finalizing a directive, (*Purchasing Home Care and Hospice Services from Community Agencies for Enrolled Veterans),* and VHA is working with the OIG to implement this final recommendation.

10. *Human Capital Management (HRA, VBA, VHA)*

Challenge Description: Human Capital Management (HCM) is a major challenge for the Department, resulting from a high number of employees projected to become retirement eligible over the next 5 years. Given the significant size of VA's work force, there are also significant dollar outlays associated with addressing this challenge effectively. GAO has also identified strategic HCM as a Government wide "high risk" area.

Risks associated with not addressing VA's HCM include:

- Patient injury or loss of life.
- Program failure.
- Significantly reduced effectiveness.
- Significantly reduced efficiency.

VHA Nurses

The VA Office of Human Resources Management (HRM) reported in FY 2001 that registered nurses are the largest segment of health care workers within the Department. VA employs approximately 35,000 registered nurses and nurse anesthetists. VAMCs are having difficulty recruiting nurses in specialty fields and some VAMCs find it difficult to recruit and retain licensed practical nurses and nursing assistants. According to HRM, 12 percent of the VA nursing population is eligible to retire. Each year, approximately 4 percent more will be eligible to retire. HRM reports that by 2005, 35 percent of the current nursing workforce will be eligible for retirement.

Recent GAO reports point to the importance Congress has placed on this issue. The following is a list of recent GAO reports and quotes of pertinent statements in those reports:

- January 2001, <u>High Risk Series</u> - "A national nursing shortage could adversely affect VA's efforts to improve patient safety in VA facilities and put veterans at risk."

- May 2001, <u>Nursing Workforce: Recruiting and Retention of Nurses and Nurse Aides Is a Growing Concern</u> - "With the aging of the population, demand for nurse aides is expected to grow dramatically, while the supply of workers who have traditionally filled these jobs will remain virtually unchanged."

- July 2001, <u>Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors</u> - "The large numbers of registered nurses that entered the labor force in the 1970s are now over the age of 40 and are not being replenished by younger registered nurses… Job dissatisfaction has also been identified as a major factor contributing to the current problems of recruiting and retaining nurses… Demand for nurses will continue to grow as the supply dwindles…The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond..."

- August 2001, <u>Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging</u> - "While current data on supply and demand for many categories of health workers are limited, available evidence suggests emerging shortages in some fields, for example, among nurses and nurse aides."

Current Status: VHA formed a National Succession Planning Task Force to address VHA's changing work force. According to the Task Force's August 2001 draft report on VHA Succession Planning, "VHA faces a leadership crisis unprecedented in its history. With 98 percent of our senior executives eligible to retire by 2005 and other key clinical and administrative cadres facing similar turnover, it is paramount that we quickly focus on both developing our new leaders as well as replacing key employees throughout our organization."

The Task Force's draft report lists recommendations in seven major categories: (i) benchmarking, (ii) workforce assessment, (iii) employee morale and satisfaction, (iv) short-term steps, (v) progression planning, (vi) legislative initiatives, and, (vii) organizational infrastructure. The report states that attracting, developing, and retaining a well-qualified workforce at all levels of VA's organization is paramount to ensure VA's ability to provide quality care to our veteran population. Recent GAO reports on management challenges cite a shortage of VHA nurses and difficulty in properly training and recruiting VBA Claims Processors as challenges for the Department.

Future Plans by VA Program Offices: National nursing shortages continue to be a priority issue for the entire health care industry. VHA maintains an ongoing, active recruitment process. There is no indication that the quality of care in VA medical centers has been adversely affected by nursing staff limitations.

VBA Claims Processing

The VA Secretary tasked a Claims Processing Task Force in May 2001 to identify the challenges VBA faces with timely and accurate claims processing. The Task Force reported that during the past decade the number of employees in VBA "dropped slightly while workload increased dramatically." The Task Force also reported that VBA reduced the availability of skilled labor for processing claims while diverting experienced staff to implement new processes that were poorly managed.

Although Congress has provided VBA an average increase of 800 employees in each of the last 2 years, VBA does not have an integrated training plan and program. The Task Force reported that VBA's Office of Employment Development and Training is not equipped to develop a comprehensive training plan. The report concludes that VBA has not put together the needed training infrastructure. The report also states that VBA's current hiring pattern is not the result of any strategy and is not integrated with any business plan. The report identifies 13 separate points in their recommendation for a fully integrated training plan and program, which includes the creation of a fully integrated training infrastructure.

Current Status: The OIG has not issued recent national audits on HCM, however we have identified resource shortages in CAP reviews.

Management Challenges Identified by the General Accounting Office

1. Access to Quality Health Care

Performance Goals:

Performance goals for this GAO challenge are the same as for IG challenge number 1 on page 161.

Challenge Description: Over the past several years, VA has undertaken many initiatives to improve veterans' overall access to VA-provided health care, such as shifting its emphasis from inpatient to outpatient primary care and increasing the number of outpatient clinics it operates. VA has also undertaken efforts to improve the quality of care it provides, including the introduction of patient safety initiatives. However, several areas require continued emphasis if VA is to achieve its goals. For example, VA cannot ensure that veterans receive timely care at VA medical facilities, nor can it ensure that it has maintained the capacity to provide veterans who have spinal cord injuries, serious mental illnesses, or other special needs the care that they require, as mandated by Congress. VA must also assess its capacity to provide long-term care for its aging veteran population and respond to emerging health care needs, such as treating veterans for hepatitis C. At the same time, VA is facing a potential shortage of

skilled nurses which, if nationwide projections for the next several years bear out, which could have a significant impact on VA's quality of care initiatives.

Current Status and Future Plans:

Access

VA has taken significant steps to improve veterans' access to health care. Over the past several years, VA has created hundreds of community-based outpatient clinics (CBOC) to provide care to veterans in outpatient settings rather than less efficient inpatient settings.

Waiting Times

In response to concerns about waiting times, VA established strategic targets for the time it takes veterans to get an appointment with a VA provider and the time they spend waiting in a provider's office. The Veterans Health Administration (VHA) has been measuring clinic appointment waiting times beginning in February 2000 using the average waiting time for next available appointment requests. VHA has also provided additional waiting times monitors to provide local managers with other perspectives on waiting time problems. Examples include average waiting time for new patients and average waiting time for established patients. VA continues to enter into short-term contracts with consultants to help reduce the backlog of specialty appointments and improve waiting times.

Quality and Patient Safety

VA has a number of initiatives underway to improve the quality of VA-provided care, including developing or revising systems for detecting and preventing adverse events that could harm patients.

Treating Veterans with Special Disabilities

The Department has adopted several performance measures to help assess the treatment of veterans with special disabilities. For example, VA is focused on promoting the health, independence, quality of life, and productivity of individuals with spinal cord injuries (SCI). We view discharge to non-institutional, community living as a positive health outcome. Consequently, one of our performance measures is the proportion of discharges from SCI center bed sections to non-institutional settings.

Shifting Health Care Needs and Workforce Issues

VA officials estimate that as much as 6.6 percent of its health care enrollees are infected with the hepatitis C virus. This is a rate three times that of the general U.S. population. Over the past 2 years, VA identified health care funding

to screen patients for hepatitis C risk factors, develop treatment protocols, and create a public health awareness campaign. VA projects spending an additional $152 million in 2001. During 2000, the Department screened over 385,000 veterans for hepatitis C. Of this total, about 4,500 patients tested positive and began therapy.

2. Health Care Resource Utilization

Performance Goals:

- Increase dollars derived from alternative revenue generated from health care cost recoveries to $1,489 million.

Challenge Description: To expand care to more veterans and respond to emerging health care needs, VA must continue to aggressively pursue opportunities to use its health care resources—including its appropriation of over $20 billion—more wisely. VA has reduced its per patient costs—one of its key performance measures—by 16 percent, but it could achieve additional efficiencies by realigning capital assets and human capital based on changing demographics and veterans' health care needs. For example, VA needs to further modify its infrastructure to support its increased reliance on outpatient health care services and expand its use of alternative methods for acquiring support services, such as food and laundry. The Department spends as much as one-quarter of its annual health care budget to operate and maintain about 4,700 buildings and 18,000 acres of property. VA also needs to pursue additional opportunities with DoD to determine cost-effective ways to serve both veterans and military personnel, including sharing services and facilities. In addition, VA must ensure that it collects the money it is entitled to from third-party payers for health care services provided to veterans whose conditions are not service-connected.

Current Status and Future Plans:

Asset Restructuring

In response to a recommendation to develop asset-restructuring plans for VA's 106 health care markets to guide planning and management of health care, VA established the Capital Asset Realignment for Enhanced Services (CARES) program. This program calls for assessments of veterans' health care needs in the future and available service delivery options to meet those needs in each health care market. VA has developed specific criteria for making these assessments.

VA began the CARES program in January 2001 in Network 12, which includes the Chicago VA medical centers. Booz-Allen & Hamilton (BAH) was awarded the primary contract to assess veteran health care needs, identify service delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets to support the delivery of health care services. BAH used actuary data from another contractor to project the health

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care needs of veterans in VISN 12 through 2010. They studied the location and condition of VA facilities, the cost of different options, the community resources available, accessibility of health care for veterans, other VA missions (for example, research and education), and VA/DoD sharing opportunities.

DoD and VA Cooperation

VA and DoD officials have sought ways to share excess health care resources. Local VA medical centers and military treatment facilities have entered into agreements to exchange inpatient, outpatient, and specialty care services, as well as support services. Some local VA and DoD facilities have entered into joint ventures, pooling resources to build a joint medical facility or capitalize on an existing facility. Local facilities and the National Acquisition Center have also arranged to jointly procure pharmaceuticals, laboratory services, medical supplies, and equipment. In 2000, the two Departments saved an estimated $51 million from jointly awarded national committed-use contracts with suppliers to purchase four percent of their total drug replacements. On a national basis, VA and DoD continue to develop memorandums of agreement to work together on cost effective acquisitions.

For additional information concerning this challenge, see "Improving Coordination of VA and DoD Programs and Services" on page 134.

Third-Party Collections

VA supplements its medical care appropriations with collections from third-party insurers. In 2000, VA collected $387 million from these insurers - $35 million less than the year before. Several factors contributing to this decline are out of VA's control. For example, more veterans are becoming eligible for Medicare, which, by law, cannot pay for VA-provided care. Also, more veterans are enrolling in managed care organizations, from which VA cannot typically collect because it is not a participating provider. In September 1999, VA began billing insurers based on "reasonable charges" for actual care provided, rather than charging rates based on average cost of care. However, reverses in declining third-party collections will not occur until VA implements its improved billing processes.

VA has begun to update its billing and records systems to bring them in line with industry standards. VA has also undertaken several initiatives to address collections weaknesses. Specifically, VA's reasonable charges were designed to be set at the 80th percentile of charges in the market area of each VA facility. We also completed much work on refining our ability to discriminate among hundreds of diagnosis related groups (DRG) and thousands of Current Procedural Terminology (CPT) codes in order to document charges to insurance companies. Adding to the complexity is the fact that insurance companies pay providers differently, depending on the presence or absence of preferred provider agreements and other contractual arrangements. Accordingly, VA is not

yet in a position to routinely verify the appropriateness of insurers' payments when they pay less than what was charged. Efforts to improve VA's ability to do this have been substantial, however, and are ongoing.

3. Compensation and Pension Claims Processing

Performance Goals:

1. Performance goals are the same as IG challenge number 3, (see page 169).

Challenge Description: VA must also continue to seek ways to ensure that veterans are compensated for reduced earning capacity due to disabilities sustained, or aggravated, during military service. VA has had long-standing difficulties in ensuring timely and accurate decisions on veterans' claims for disability compensation. VA has improved its quality assurance system in response to GAO's recommendations, but large and growing backlogs of pending claims and lengthy processing times persist. Moreover, veterans are raising concerns that claims decisions are inconsistent across VA's regional offices. VA has taken steps to improve its information systems, performance measures, training strategies, and processes for reviewing claims accuracy.

However, VA also needs better analyses of its processes in order to target error-prone types of cases and identify processing bottlenecks—as well as determine if its performance goals are realistic. VA also needs to be vigilant in its human capital strategies to ensure that it maintains the necessary expertise to process claims as newly hired employees replace many experienced claims processors over the next 5 years.

Current Status and Future Plans: VA has addressed a number of key management issues. These include implementing new performance measures, modernizing its information technology systems, and developing training. However, many experienced staff are expected to retire and veterans are seeking compensation for more service-connected disabilities per claims. Claims processing is more complex due to increasing procedural and documentation requirements.

VA has taken steps to offset the impact of legislative and regulatory changes on timeliness and accuracy by implementing countermeasures using available resources. The Under Secretary for Benefits presented the Department's strategies in a satellite broadcast to regional offices in March 2001. As of this time, we have successfully implemented the following measures in FY 2001:

*   As of June 30, 2001, a total of 932 Veterans Service Representatives (VSRs) and Rating VSRs have been hired.

- In March 2001, the Veterans Benefits Administration (VBA) launched its centralized training initiatives to train these new hires. This centralized training is now the standard for training future hires.

- VBA reached an agreement with the Board of Veterans Appeals (BVA) concerning remand development. By January, 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices.

- Nine Resource Centers were established to focus on specialized claims processing.

- The St. Louis Helpline was expanded and fully operational by February 2001.

- Several decision notification letter packages prepared in an enhanced PCGL were released in April and November 2001. A work group has developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.

- The amendment to the Code of Federal Regulations (38 CFR 3.103) allowing VBA's decision-makers to gather evidence by oral communication was published in the Federal Register on April 20, 2001.

- The Compensation and Pension Records Interchange (CAPRI) application that allows VBA's decision-makers to successfully obtain medical records from the Veterans Health Administration database was successfully tested in January 2001. This application will be available to all regional offices by the end of this fiscal year.

- VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify the tools and procedures needed to improve the quality and timeliness of C&P examinations. It is currently functioning and recruitment is underway for all the necessary subject matter experts from both VBA and VHA.

4. Management Capacity

Challenge Description: VA has more work to do to become a high-performing organization and increase veterans' satisfaction with its services. It must revise its budgetary structure and develop long-term, agency-wide strategies for ensuring an appropriate information technology (IT) infrastructure and sound financial management. If its budgetary structure linked funding to performance goals, rather than program operations, VA and the Congress would be better positioned to determine the Department's funding needs. VA's IT strategy, which aims to provide veterans and their families coordinated services,

must be successfully executed to ensure that VA can produce reliable performance and workload data and safeguard financial, health care, and benefits payment information. Similar to most other major agencies, VA's financial management strategies must ensure that its systems produce reliable cost data and address material internal control weaknesses and Federal Financial Management Improvement Act requirements.

Current Status and Future Plans

Performance-based Budgeting

VA and OMB staff jointly developed a proposal to restructure the Department's budget accounts. The goal of this account restructuring effort is to facilitate charging each program's budget accounts for all of the significant resources used to operate the program and produce its outputs and outcomes. The benefits of budget account restructuring are: (1) to more readily identify program costs; (2) to shift resource debates from inputs to outcomes and results; (3) to eventually make resource decisions based on programs and their results rather than other factors; (4) to improve planning, simplify systems, enhance tracking, and focus on accountability.

VA's Administrations and staff offices have endorsed this proposal. While OMB approves of the concept, we are still discussing many of the details of the new structure with them. In addition, we have started consultation sessions with our appropriations committees. Both the Senate and House appropriations committee staffs agree with the basic thrust and goals of the account restructuring proposal. We will continue to work with our major stakeholders on specific implementation issues.

Information Technology

GAO has identified seven challenges for VA to strengthen the leadership and management of its IT initiatives. These challenges, and the status of each, are summarized in the table below:

Challenge	Status
Appointment of Chief Information Officer	In 1998, VA established the position of Assistant Secretary for Information and Technology to serve as VA's Chief Information Officer (CIO). On July 17, 2001, John A. Gauss was nominated to be Assistant Secretary for Information and Technology in the Department of Veterans Affairs. He was confirmed by the Senate on August 3, 2001.
IT investment management	VA has established a process for selecting, controlling and evaluating its IT capital investments. The following efforts are under way to implement the improvements GAO recommended: 1) VA has retained a contractor to assist in conducting formal in-process reviews at key project milestones and 2) providing data to decision-makers on lessons learned from post-implementation reviews. VA

Challenge	Status
	developed guidance to better manage projects below thresholds established by VA's Strategic Management Council, and has issued the IT Capital Investment Guide (http://www.va.gov/OIRM/IT Planning/IT_Capital_Investment_guide).
Integrated business process reengineering	VA maintains that business process reengineering is the principal responsibility of the process owner, but it must be consistent with the Department's Enterprise Architecture (EA) and Strategic Plan. The proposed EA will be submitted to the Secretary for signature before the end of FY 2001. Once approved, the Department's CIO or designee will work closely with all business owners to develop a logical architecture and an integrated IT architecture.
Integrated IT architecture	The Secretary's department-level innovation team has completed its work to: • Define Enterprise Architecture (EA) principles; • Select an EA framework; • Develop an EA strategy and governance process. The team has drafted and given unanimous concurrence to a strategy and governance document, which will be submitted to the Secretary for approval prior to the beginning of FY 2002. The proposed EA, which is defined at the One-VA level, will replace the separate administration architectures. It will be business and service focused and will require that sponsors of all new IT initiatives: • Clearly identify and measure the service improvements that their project will provide; • Demonstrate that the service they propose is not provided or being developed elsewhere within VA; • Show their approach will yield a system that is interoperable, scaleable and adaptable to evolving technologies.
Tracking IT expenditures	VA has delegated the responsibility for tracking IT expenditures to managers in the Administrations and staff offices.
Assessing IT performance	As part of VA's Capital Investment Process, IT initiatives undergo an Execution Review to assess project conformance with planned costs and schedule goals. Additionally, initiatives are potentially subject to In-Process Reviews at points in their development cycle. Post-Implementation Reviews are conducted on initiatives once they are fully deployed. Results of these reviews and studies are made available to decision-makers in the Capital Investment Process to assist in making decisions about continued funding of initiatives.
Computer Security (see also OIG's management	See narrative under Item 6 "Security of Systems and Data" (p. 176)

Challenge	Status
challenge on IT Security)	

Financial Management

VA has made substantial progress in implementing GAO's recommendations for gaining accountability and control over its direct loan and loan sales activities, and for complying with credit reform accounting requirements. For more information, see the OIG's management challenge about VA's Consolidated Financial Statements on page 178.

Assessment of Data Quality

Due to diligent efforts over the past several years, the quality of VA data is good – not perfect, but very usable. Our efforts have taken many forms -- each program office initiated specific improvement actions; the Office of the Inspector General (OIG) conducted a series of audits to determine the accuracy of our data; we established a Department-level Chief Actuary to assist program officials in assessing the validity and accuracy of performance data; and our budget office worked with program officials to prepare an assessment of each key measure.

After identifying corporate data issues, a coordinated effort was made to improve the quality of the data we collect. For example, VHA established a data quality council to lead their improvement efforts. The council's focus has been centered on:

- Creating standard processes that support on-going maintenance of data quality;
- Defining and implementing local accountability for data quality;
- Establishing a data quality education, training, and communication structure;
- Focusing efforts on data that support patient access processes.

OIG audits are an integral part of our data quality assessment efforts. We consider OIG reviews to be independent and objective. For each VA program, we collect a great deal of information from veterans and other users through customer satisfaction surveys. We are continually improving our survey processes and standards -- a long-term project. The following discussion describes in specific detail the actions each VA Administration has taken to improve its data quality.

Veterans Health Administration

Data reliability, accuracy, and consistency have been a targeted focus of the Veterans Health Administration (VHA) for the past several years. The principles of data quality are integral to VHA's efforts to provide excellence in health care. In FY 2001, the Under Secretary for Health commissioned a new high-level crosscutting task force on data quality and standardization, co-chaired by two Chief Officers (Quality and Performance and Policy and Planning). In its early stage of development, this task force will focus on strategic planning to provide consistent definitions of clinical and business data for more effective clinical and organizational decision support.

VHA has long been recognized as a leader in documenting credentials and privileges of VA health care professionals. In FY 2001, VHA implemented a new electronic data bank, VetPro, on health care professionals' credentialing in partnership with the Department of Health and Human Services. VetPro

promotes and demonstrates to other federal and private agencies the potential of a secure, easily accessible, valid data bank of health professionals' credentials.

VetPro improves the process of ensuring that health care professionals have the appropriate credentials for their clinical roles. It will also help VHA verify that practitioners have a good and desirable track record, consistent with high-quality and safe patient care. When a doctor or dentist is credentialed using VetPro, a permanent electronic file is created that will be accessible across the VA system and other federal health care programs. As VetPro is used, the process of updating credentials will be streamlined because files will not be redone from scratch. As providers add information, it will be verified by the credentialers who create the permanent record. The Joint Commission on Accreditation of Health Care Organizations reviewed VetPro and stated, "The program appears, if used as designed, to be consistent within considerable detail with the current Joint Commission Standards..."

In 1998, the Under Secretary for Health convened a data quality summit and tasked VHA's Chief Information Officer with leading the effort to address identified issues. Outcomes of the summit are described below.

A VHA Data Consortium was formed to address organizational issues and basic data quality assumptions. The Data Consortium works collaboratively to improve information reliability and customer access for the purposes of quality measurement, planning, policy analyses, and financial management. The ongoing initiatives and strategies address data quality infrastructure, training and education, personnel, policy guidance, and data systems.

In July 2000, VHA hired a full-time data quality coordinator. The coordinator, along with data quality workgroups, provides guidance on data quality policies and practices. Several initiatives underway that support the integrity and data quality of coding include:

• Development of strategies and standard approaches to help field staff understand the data content and meaning of specific data elements in VHA databases;

• Development of coding resources for field facilities, to include negotiating the purchase of knowledge-based files/edits from Ingenix™ for use within the Veterans Health Information Systems and Technology Architecture (*VistA*). This supports the use of national code sets, Current Procedural Terminology, 4th Edition (CPT-4), and Health Care Financing Procedural Coding System (HCPCS) Level II. The availability of these code sets will enable VHA to accurately describe outpatient and other professional services provided to patients;

• Complete revision of *VistA* software to accommodate the use of national code set modifiers, giving providers the ability to document care more completely and accurately.

To support the need for guidance in medical coding, VHA established the Health Information Management (HIM) Coding Council. The council, comprised of a panel of credentialed expert coders with support from VHA HIM Headquarters' staff, researches and responds within 24 hours to coding questions, citing official references. The council also updates the national coding handbook, which provides expert guidance to field facilities. This handbook standardizes guidelines for complete and accurate coding.

VHA's Office of Information sponsors the "*Close Encounters*" newsletter, which provides expert guidance to field facilities on encounter forms, insurance billing, coding, and Medicare compliance. It also sponsors a data quality newsletter, "*Data Quality Highlights,*" which provides data quality facts and tips.

Training and education opportunities that support data quality initiatives and compliance (such as the airing of national satellite broadcasts on data quality issues) are provided to staff. Future topics include external impacts on data reliability, guidance from the Centers for Medicare and Medicaid Services, national standards bodies issuance, and internal data requirements of the Veterans Equitable Resource Allocation (VERA) funding model.

In an effort to improve the reliability of Decision Support System (DSS) data, a directive on standardization was released to all VA medical facilities. The directive provides guidance for the standardization of managerial accounting and serves as a clinical information tool to assess the delivery of medical care across facilities.

In addition to guidance, training, and education, the Office of Information is involved in several key projects that are targeted to improve data quality and system reliance. These include the Meta Data Repository (MDR) and the Master Patient Index (MPI). The MDR houses data from 49 VHA databases. This registry contains definitions, business rules, names of database stewards, and descriptive information about the data elements contained in **V***ist***A** databases. The MDR was released to a limited audience of data users in January 2001. General release will be completed in the fall of 2002. The MDR provides a single source of data element description to users and technical staff. Use of the MDR will also help eliminate data redundancies and improve standardization.

VHA also completed the implementation of a national MPI in FY 2001. MPI provides the ability to view clinical data from various VA medical facilities via the remote data view functionality within the Computerized Patient Record System (CPRS). MPI provides the access point mechanism for linking patient information from multiple clinical, administrative, and financial records across VHA health care facilities, enabling an enterprise-wide view of individual and aggregate patient information. Responsibility for MPI data integrity exists on both corporate and facility levels. This effort will be accomplished through the

use of software reporting tools and interaction with both sites of care and external authoritative sources.

Future Efforts

VHA is in the process of examining its current health information processing environment in order to plan how to best implement improvements over the next 5 years. As part of this process, VHA is assessing:

- What a high-performance automated health system needs to provide;

- What the ideal health and information system would look like;

- What the advantages and disadvantages are of our current system;

- How best to use a phased approach for moving from the current to the ideal environment.

VHA intends to pursue efforts to move toward an ideal health and information system. This system would promote the sharing of information any time, any place, by any authorized provider, and in real-time, while ensuring that stringent privacy and security regimes are maintained. It would maximize use of the best available technology to allow users to effectively manage across programs, time, and distance, and within budget constraints, while balancing the resource needs of health and information. The ideal health and information system would provide a high-performance platform that maximizes patient health.

In the near term, VHA will enhance the current **V**ist**A** platform by completing the Decision Support System and implementing **V**ist**A** Imaging. Based on the availability of funds, mid/long-term efforts will include the development of a health database accessible across all levels of care, times, locations, and providers; the enhancement of Eligibility/Enrollment processing to meet One VA goals; the reengineering of the **V**ist**A** Scheduling package; and enhancement or replacement of the Billing and Fee Basis Systems. The following narrative provides a description of these projects:

All-VA **Registration**

This effort will involve forming a collegial partnership with Departmental counterparts (VHA, VBA, and NCA) to explore a seamless continuum of registration and eligibility services to improve access to veterans' benefits and information on veterans' health status and improve customer service relationships with the veteran population. While the effort will be challenging given the disparate nature of many of the systems and processes associated with these entities, it offers opportunities to improve the quality of and access to data, enhance services to veterans, and realize cost-efficiencies through an integrated Department systems approach. Current information sharing and communication tools hamper access to the administrative information needed for daily

operations. Yet all VA programs have the need for a common set of demographic and eligibility data for their individual core business functions. The goal of this phase of the project is to create an authoritative database accessible to all VA components that require veteran information.

The *All-VA* registration system will hold all administrative data common to VA program areas. It will contain data on every veteran and dependent. Data on a subset of veterans will comprise the National Demographic Database. An Expert Eligibility System will be created to automate the determination of a veteran's eligibility for various veteran and dependent benefits. The eligibility determination system is rule-based, supporting ease-of-change to eligibility rules with immediate reassessment of potential eligibility. The system will determine eligibility as of specified dates in the past, basing its determination on the statutory eligibility rules in force on those dates. This will incorporate a centralized concept of all eligibility data, including the financial portion of eligibility determination.

Replacement of V*ist*A Integrated Billing and Accounts Receivable System

The billing and accounts receivable modernization project will continue the trend towards industry standardization. It will include required functionality of the existing application, as well as additional necessary functionality identified through previously conducted requirements analysis. The information system will interact with all current and future systems that support the registration, billing, and accounts receivable processes.

The transformed billing and accounts receivable system will also move VHA health care in the direction of industry standards, in that it will utilize account-based management. VA currently uses bill-based management, in which non-billable treatment and services are not entered into the billing application. In an account-based management system, a patient's account is started when he/she arrives for care, and flows to the billing system regardless of billability. If not billable, a bill will not be generated. This allows for accurate potential revenue calculation and projection.

Fee Basis

The Fee Basis portion of the above initiative supports VHA's efforts to improve operations, comply with impending health care regulations within the Health Insurance Portability and Accountability Act that require the acceptance of electronic claim submissions, control its costs, and prevent fraud and abuse. Fee Basis operations have been the subject of several internal and external studies in which reengineering, process, and organizational redesign have been recommended and piloted, but not implemented across the country. The transformation of the Fee Basis process, together with the replacement of Central Fee by the core Financial and Logistics System (coreFLS), will facilitate a redesigned and improved Fee Basis process. A new system will allow the Fee

Basis process greater flexibility in terms of location, volume, and type (manual vs. automated) of processes being performed. Replacing Central Fee and IFCAP, the main interfaces of Fee Basis, with one commercial product will ease the implementation and the resulting processes.

In addition to process improvement, a new system will accommodate increased clinical data capture and have the flexibility to capture workload data currently being missed and/or not reported correctly. This will have several effects on the Fee Basis program. First, the program will function to accurately account for the services for which VHA is paying. Next, it will allow Veterans Integrated Service Networks (VISNs) and medical centers to appropriately capture their actual workload. Also, VISNs and medical centers will be able to provide Fee patients a full continuum of care, regardless of the location of care, by capturing the services performed by non-VA providers. Finally, the new Fee Basis system will allow VHA to pursue reimbursement from the patient's insurer with medical documentation if appropriate.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) steadily continues to improve its data systems and the integrity of information within those systems. When it comes to delivering $27.9 billion in benefits annually to more than 3.2 million veterans and their families, VBA believes data integrity must remain a core competency.

For many years, data integrity has been a significant concern for VBA. Eliminating the practices of manipulating numbers and allowing incorrect input into essential reporting systems has been a primary focus. As outlined in its *Roadmap for Excellence*, VBA created the Data Management Office (DMO) in 1998 to incorporate a strong focus on administration-wide data integrity. The DMO plays a key role in this effort, working in concert with all VBA components.

Data integrity requires improving the information we collect and publish regarding veterans and dependents and the operations of VBA's five business lines. The data that are collected must lead to accurate, current, consistent, and germane information that serves the needs of internal and external users now and in the future. A key initiative in fostering data integrity is the deployment of a balanced scorecard approach to measuring organizational performance. Using this methodology, performance is measured consistently from the national level down through the regional offices. Maintained by the DMO and delivered via Intranet technology, the balanced scorecard provides VBA employees, managers, and executives with a better understanding of organizational strengths and areas for improvement in a timely and consistent manner. The balanced scorecard promotes information sharing and cooperation within VBA, which directly improves the delivery of benefits to veterans. Results from the balanced scorecard are shared

with external stakeholders such as Congress and veterans service organizations during quarterly briefings.

To ensure the integrity of transactions in the compensation and pension (C&P) business line, data regarding specific transactions that appear suspect are posted to the C&P Service Intranet Web site. Stations monitor this site and review those transactions that appear questionable (for example, multiple work credits taken on the same case within a short period of time, or a very short period of time between the establishment of the claim and the disposition). The C&P Service tracks station reports to ensure proper review and corrective actions are taken. This process has resulted in a reduction of suspect transactions and has helped identify areas for training or policy clarification.

Another major initiative to facilitate data-driven decision-making is VBA's Operations Center, an Intranet portal supported by user-friendly analytical tools, where the balanced scorecard and other core business information are made available for review and analysis. The Operations Center provides all levels of employees and managers with the same data used in decision-making and performance reporting. This wide dissemination of data ensures that constant review and analysis take place, facilitating improved data validation, and ultimately, improved service to veterans.

VBA's data warehouse and operational data store support the Operations Center. Both these technology environments, and their accessibility to end-users via the Intranet, dramatically improve the reliability, timeliness, and accuracy of core business information. Data collection and dissemination that once took weeks are now completed inexpensively and efficiently and are available on-line for review and analysis. Because the data are so accessible, anomalies or inconsistencies are readily noted and corrective action can be taken.

Facing the challenge to modernize systems and improve data integrity, VBA has made great strides in the past 3 years to ensure the quality of information and data-driven decision-making. The continued refinement of processes and systems, including the construction of a single corporate database where consistent information is available regarding veterans and business transactions conducted for those veterans, remains a key focus of VBA. These efforts, building upon a modernized infrastructure, ultimately lead to improved delivery of benefits and services to veterans and their families.

National Cemetery Administration

National Cemetery Administration (NCA) workload data are collected monthly through field station input to the Management and Decision Support System, the Burial Operations Support System (BOSS), and the Automated Monument Application System-Redesign (AMAS-R). After reviewing the data for general conformance with previous reporting periods, headquarters staff validates any irregularities through contact with the reporting station.

NCA determines the percent of veterans served by existing national and state veterans cemeteries within a reasonable distance of their residence by analyzing census data on the veteran population. Since FY 2000, actual performance and the target levels of performance have been based on the new VetPop2000 model developed by the Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It is the first revision of official estimates and projections since 1993. The new VetPop2000 methodology resulted in significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the separate county veteran populations from which NCA determines the percentage of veterans served.

For FY 2001 and subsequent years, NCA has developed a new customer satisfaction survey process to measure the quality of service provided by national cemeteries as well as their appearance. The new survey provides statistically valid performance information at the national and regional levels and at the cemetery level (for cemeteries having at least 400 interments per year). The annual survey is done via mail; the data are collected from family members and funeral directors who recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. VA headquarters staff oversees the data collection process and provides an annual report at the national level.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed new codes for ordering replacement headstones or markers; use of these new codes produces reliable and accurate data on replacement actions and provides management with an effective tool for improving the overall business process.

Office of Inspector General (OIG) Audits

The OIG continued its assessment of the accuracy and reliability of VA's key performance measures in accordance with the Government Performance and Results Act. During FY 2001, we continued an assessment of the Chronic Disease Care Index (CDCI) and Prevention Index (PI), and initiated an audit of the Vocational Rehabilitation and Employment Rehabilitation Rate. The OIG assessed the procedures used by VHA to compute the CDCI and PI indices during FY 2000 and demonstrated that these were adequate. During FY 2001, we began a review of the appropriate source documents to determine the validity of data used in computing the CDCI and PI. This audit will be completed during FY 2002.

To date, the OIG has completed audits of six key measures, and we plan to conduct several others in the near future. We will confer with program and other key officials during the second quarter, FY 2002, to determine which key measures should be the next ones to audit.

Crosscutting Activities

To assist us in achieving our goals and objectives, VA has formed numerous partnerships and alliances with other Federal agencies, state and local governments, and private sector organizations. These crosscutting activities have the potential for providing improved delivery of service to our veterans through administrative simplification, reduction of barriers, better allocation of limited resources, and achievement of cost savings. They provide a clear focus on measurable outcomes. In addition, VA anticipates working with other agencies and Departments in crosscutting activities such as data sharing with Centers for Medicare and Medicaid Services (CMS) and DoD.

Department	VA Business Line and Activity
Commerce	**Insurance** • In conjunction with the Dept. of Commerce, VA coordinates and monitors SGLI/VGLI activities for NOAA. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
Defense	**Medical Care** • In conjunction with DoD, VA develops and implements clinical practice guidelines with a long-range view toward assuring continuity of care and a seamless transition for a patient moving from one system to the other. • VA's Office of Environmental Hazards works with DoD to address war-related medical issues. The two agencies participate jointly in the following standing committees: Gulf War Program; Veterans Health Coordinating Board on Gulf War Illnesses; and the Canadian and UK Gulf War Veterans Advisory Committee. • VA's AIDS Service works with The Office of the Secretary of Defense (OSD)/Force Management and Readiness Committee to understand and interpret disability ratings for active military personnel with HIV. • With DoD and GSA, VA distributes excess property (sleeping bags, blankets, and clothing) for homeless veterans. The Compensated Work Therapy (CWT) Program at the VA New Jersey Health Care System employs formerly homeless veterans to unload, inventory, and ship these goods across the country. • Four traumatic brain injury (TBI) lead centers have been jointly established and cooperatively funded by VA and DoD to receive and screen all TBI patients and maintain a national registry of TBI patients. • VA, by Public Law 97-174, has the added mission to serve as principal health care backup to DoD in the event of war or national emergency. VA, at the request of DoD, may authorize DoD to use its medical facilities (hospital and nursing home care), medical services, office space, supplies, and administrative support. • VA partners with DoD's Pacific e-Health Center in Honolulu, HI, to provide peer consultation and patient care to participants separated by distance. • VA and DoD participate in the Alaska Federal Health Care Partnership, with a goal of providing specialized care to isolated or remote patient populations in Alaska.

Department	VA Business Line and Activity
Defense (cont'd)	**Medical Education** • VHA's Office of Public Health and Environmental Hazards works with DoD in the development and subsequent changes to smoking cessation guidelines. This is being done to standardize smoking cessation practices for active military personnel as well as for veterans. **Medical Research** • The Cooperative Studies Program collaborates with DoD on a number of studies, including an antibiotic treatment trial and an exercise/behavioral medicine treatment trial for Gulf War Syndrome. • DoD participates in a nationwide study assessing the rate of amyotrophic lateral sclerosis (ALS), or Lou Gehrig's disease, among veterans who were on active duty during the Gulf War. **Compensation and Pension** • VA is working with DoD officials to support claims development and the physical examination process prior to separation. VA encourages national, state, and county VSOs to be an integral part of the execution in this effort. • VA is working with DoD and National Personnel Records Center (NPRC) to develop the electronic control and exchange of military records and service verification. • VA is working to expand its relationship with the Defense Manpower Data Center (DMDC) to interface and use more of their data. This will provide the opportunity for potentially reducing overpayments caused by dual benefit payments using on-line matches against DMDC databases. **Education** • VA works with DoD to provide educational assistance to veterans and servicemembers. These benefits are an important DoD recruiting tool. **Insurance** • VA coordinates and monitors SGLI/VGLI activities for the Army, Air Force, Marines and Navy. VA receives and monitors SGLI premium payments, monitors death claims against SGLI and monitors the maximum coverage limit. VA receives data on recently separated reservists and recently discharged seriously disabled retirees for VGLI outreach efforts. • VA monitors NSLI/SDVI activities by establishing and monitoring allotments from retired pay and assuring that addresses are correct. **Burial** • VA works closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. • VA provides headstones and markers for national cemeteries administered by the Department of the Army and the American Battle Monuments Commission. In addition, Arlington National Cemetery, which is administered by the Department of the Army, orders headstones and markers directly through VA's AMAS-R monument ordering system. VA also contracts for all niche inscriptions at Arlington National Cemetery.

Department	VA Business Line and Activity
Interior	**Burial** • VA provides headstones and markers for Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by the Department of the Interior. In addition, these cemeteries order headstones and markers directly through VA's AMAS-R monument ordering system.
Agriculture	**Medical Care** • VA works with Agriculture's National Rural Development Council to identify how VA's Telemedicine capability may be utilized to provide specialized patient care to rural populations. • VA participates in joint design and construction projects.
FEMA	**Medical Care** • The Federal Response Plan outlines how agencies will implement the Robert T. Stafford Disaster Relief Act that stipulates the Federal Government will provide assistance to state and local governments during times of disasters or terrorist attacks. VA is responsible for providing support under four of twelve functional areas of the Plan. VA is most often called upon to provide medical assistance.
HHS	**Medical Care** • VA works with HHS to develop non-VA benchmarks for bed days of care, which are obtained from a CMS database. VA obtains data on ambulatory procedures from the National Center for Health Statistics. • VA participates with the National Cancer Institute, DoD, and the American Diabetes Association on the Joslin Diabetes Telemedicine Project. • Improving mammography and cervical cancer screening rates includes collaboration with the National Center for Health Promotion and liaisons with other private and public health care agencies involved in women's health. • VA's AIDS Service is working closely with HHS' Health Resources and Services Administration (HRSA) to develop collaboration in the Ryan White CARE Act related provision of services to veterans with HIV. • VA collaborates with HHS' HRSA to create credentialing and privileging guidelines for clinicians providing patient care through use of telemedicine technology when participants are separated by distance. • An Interagency Agreement with the National Institutes of Health/National Library of Medicine provides for information kiosks to be placed in selected VA medical centers to enhance the capabilities of VA patients and their caregivers to have immediate access to current information about HIV disease. • VA participates in joint design and construction projects with HHS and specifically the U.S. Public Health Service and the Indian Health Service. **Medical Education** • VA works with the American Diabetes Association, the Centers for Disease Control and Prevention, and other organizations in the education of providers and persons with diabetes in the prevention of foot problems

Department	VA Business Line and Activity
HHS (cont'd)	through the "Feet Can Last a Lifetime" Project.
	• VA's National Center for Patient Safety is working with the Department of Health and Human Services' Patient Safety Task Force and is collaborating with the Centers for Disease Control and Prevention, the Food and Drug Administration, the Agency for Healthcare Research and Quality, and the Health Care Financing Administration to implement new initiatives in Patient Safety, based on VA and joint VA/NASA experience.
	Medical Research
	• VA disseminates results from the National Institute on Aging (NIA) Collaborative Studies of Dementia Special Care Units and from VA-sponsored research on dementia care. VA also explores areas of research collaboration on Alzheimer's and related dementia, including medical, rehabilitation, and health services research.
	• VA and NIDA are working together to evaluate new pharmacological treatments for substance abuse. This partnership conducts clinical trials of possible treatments for abuse of alcohol and other drugs.
	• VA has entered collaborations with the NCI and the Southwest Oncology Group to study whether selenium and Vitamin E, alone or in combination, prevent prostate cancer.
	• VA is now working with the National Institute of Allergy and Infectious Disease to determine if a vaccine can prevent shingles. Approximately 37,000 volunteers will help study whether the vaccine offers protection against the painful skin and nerve infection that is common among the elderly.
	• HSR&D met with CDC in July to discuss opportunities to collaborate on projects. "Translating Research into Action for Diabetes" (TRIAD) was identified as a project that will allow the benchmarking of VA diabetes care with the care of diabetics in the private sector. The proposal was submitted by VA's Diabetes QUERI where it was approved and will start immediately.
	• HSR&D and CMS continue to work together toward a merging of the VA patient database with CMS's database.
	• VA's Cooperative Studies Program is collaborating with CMS to evaluate the economic differences between different means of erythropoiten administration to dialysis patients.
	Insurance
	• VA coordinates and monitors SGLI/VGLI activities for the Public Health Service. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
HUD	**Medical Care**
	• VA and HUD jointly sponsor the HUD-VA Supported Housing (HUD-VASH) Program for homeless veterans in 35 locations across the country. VA clinicians provide ongoing case management and other needed assistance to homeless veterans who have received dedicated Section 8 housing vouchers from HUD.
Interagency	**Medical Research**
	• VA serves on the Interagency Council on the Homeless. The Secretary,

Department	VA Business Line and Activity
Interagency (cont'd)	Department of Veterans Affairs is the Co-Vice Chair. The Interagency Council on the Homeless serves as a forum for the exchange of information to ensure coordination of Federal efforts to assist the Nation's homeless population. **Insurance** • VA meets annually with the SGLI Advisory Council, which is made up of representatives of the Departments of Treasury, Defense, Commerce, HHS, Transportation and OMB to review the operations of the SGLI program. The group discusses potential legislative changes to the program such as the spousal and dependent coverage and the maximum coverage increase added this year. • **Compensation and Pension** VA is a participating member of NRC's Federal Facilities Council, a cooperative organization of 19 Federal agencies with interests and responsibilities related to all aspects of facility design, acquisition, management, and evaluation.
Justice	**Medical Care** • VA and DoJ's Bureau of Prisons (BoP) are creating a model to use VA's telemedicine capability to provide specialized health care to BoP's population. **Burial** • An Interagency Agreement with the Bureau of Prisons provides for the use of selected prisoners to perform work at national cemeteries. This agreement provides a supplemental source of labor to assist in maintaining the national cemeteries.
Labor	**Medical Care** • DOL's Homeless Veterans Reintegration Project (HVRP) grant recipients coordinate their efforts to assist homeless veterans with employment and vocational training with VA's Health Care for Homeless Veterans (HCHV) Programs and Domiciliary Care for Homeless Veterans (DCHV) Programs. **Education** • With Commerce and Agriculture, DOL helps VA by conducting approval and oversight activities for job training programs. **Vocational Rehabilitation and Employment** • VA partners with DOL to conduct training on employment assistance and techniques including referrals of job-ready veterans to DOL's America's Job Bank Internet site.
NASA	**Medical Care** • VA's National Center for Patient Safety is working with NASA to develop and implement an external, voluntary, identified adverse event and close call reporting system for VHA nationally.
National Academy of Sciences	**Medical Research** • VA Research Service is collaborating with other agencies in the Institute of Medicine's Pathophysiology and Prevention of Adolescent and Adult Suicide initiative to develop strategies and research designs

Department	VA Business Line and Activity
	for the study of suicide and its prevention. VA is particularly interested in suicide among the elderly.
NRC	**Medical Education** • VA is among the 17 Federal agencies participating in the Federal Radiological Emergency Response Plan (FRERP). The purpose of the FRERP is to establish and organize an integrated capability for a timely and coordinated response by Federal agencies to peacetime radiological response. Authorities for this Plan are P.L. 96-295 and E.O. 12241. **Medical Research** • VA's Office of Public Health and Environmental Hazards works with NRC and the Institute of Medicine on research concerning herbicides, Agent Orange exposure, and the health status of Vietnam era veterans. **Medical Education** • VA's Office of Public Health and Environmental Hazards supports the NRC's medical education on Gulf War veterans.
SSA	**Medical Care** • Health Care for Homeless Veterans (HCHV) Programs staff and Domiciliary Care for Homeless Veterans (DCHV) Programs staff coordinate outreach and benefits certification at three sites to increase the number of eligible homeless veterans who receive SSI and SSDI benefits and to otherwise assist in their rehabilitation. **Compensation and Pension** • VA is a participating member of NRC's Federal Facilities Council, a cooperative organization of 19 Federal agencies with interests and responsibilities related to all aspects of facility design, acquisition, management, and evaluation. **Insurance** In conjunction with Social Security, VA obtains assurances of correct addresses of NSLI and SDVI policyholders and beneficiaries, obtains dates of death from Social Security's Death Master File and verifies social security numbers.
DOT	**Insurance** • VA coordinates and monitors SGLI/VGLI activities for the Coast Guard. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
International	**Medical Research** • The Cooperative Studies Program works with the Medical Research Councils of the United Kingdom and the Canadian Institutes for Health Research in planning a study designed to determine the optimal anti-retroviral therapy for AIDS and HIV infection.
State/Local	**Medical Care** • VA's Homeless Grant and Per Diem Program provide grants to community-based organizations, state or local governments, or Native American tribes to assist with the construction or renovation of new transitional beds and other supportive services programs. Grant recipients may receive per diem payments to help offset operational expenses for their programs for homeless

Department	VA Business Line and Activity
State/Local (cont'd)	veterans.
	• VA maintains community-based Vet Centers through continued outreach contacts with all aspects of the veterans' community and local service providers.
	• VA's State Home Program provides a grant to states to assist with the construction or renovation of nursing home, domiciliary or adult day health care facilities. Following completion of construction, VA recognizes these facilities as State Veterans Homes and provides four different per diem grants related to the provision of nursing home, domiciliary, adult day health care or hospital care to eligible veterans.
	• VA's National Center for Patient Safety is providing training and advice in human factors, adverse event and close call reporting and analysis systems to staff from Baylor University, Dartmouth University, Thomas Jefferson University, the University of Michigan, the University of Pennsylvania and the University of Texas.
	• VA's NCPS is providing advice on how to develop and use error reporting systems for Michigan health care systems as guided by Michigan Peer Review and Michigan's "Leap Frog" group.
	• Under VA's Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Homeless Veterans, VA medical centers work with representatives from other Federal agencies, state and local governments and community-based service providers to identify the unmet needs of homeless veterans and develop action plans to meet these needs.
	Burial
	• VA partners with the states to provide veterans and their eligible family members with burial options in a national or state veterans cemetery. VA administers the State Cemetery Grants Program, which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries that are owned and operated by the states.
	• VA encourages state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system.
	• VA extends its second inscription program to state veterans cemeteries. In this program, the second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.
White House	**Medical Care**
	• VA has close liaison with the Office of National Drug Control Policy, whose national drug strategy significantly informs VA's addictive disorders treatment goals.
	Burial
	• VA administers the White House program for issuing Presidential Memorial Certificates to the deceased veteran's next of kin and other loved ones,

Department	VA Business Line and Activity
	conveying the Nation's gratitude for the veteran's service.
Veterans Service Orgs.	**Medical Research** • Eastern Paralyzed Veterans Association: EPVA provides support for meritorious career development candidates and has just begun a new initiative to fund small projects proposed by spinal cord clinicians. • VA has established an MOU with the American Legion to share workload data to facilitate American Legion reviews of VA medical centers. Similar sharing with other service organizations is under study. • VA has a liaison agreement with the Paralyzed Veterans of America to partner in developing the functional design of spinal cord injury (SCI) facilities to ensure SCI service centers best meet customer needs.
Private	**Medical Care** • VA will continue to work with the Paralyzed Veterans of America and other concerned veterans service organizations to ensure VHA continues to improve its excellent spinal cord-injured care. • VA works closely with the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in regard to general accreditation issues as well as specific patient safety programs. • VA works with the National Academy of Sciences' Institute of Medicine to provide strategic direction for the clinical, research, education, and outreach programs for veterans who have health problems, possibly as a result of exposure to Agent Orange and other herbicides used in Vietnam. • VA works together with nonprofit organizations, including VSOs, to enhance assistance to homeless veterans. VA collaborates with U.S. Vets, Inc., and the Corporation for National Service to expand AmeriCorps member services to homeless veterans. • VA's Chaplain Service partners with religious organizations to help re-establish community support systems for homeless veterans. • VA medical centers and VA regional offices collaborate with community service providers, including VSOs, to hold Stand Downs for homeless veterans. At Stand Downs, homeless veterans receive clothing, haircuts, food, health screening, benefits assistance, information about housing and employment opportunities and access to longer-term treatment programs. • Under sharing agreements and enhanced use lease agreements, VA medical centers are making underutilized properties available to nonprofit organizations to develop supported housing programs for homeless veterans. **Medical Research** • VA's Medical Research Service and the Juvenile Diabetes Foundation (JDF) have established a partnership against diabetes. Special centers in Iowa City, Nashville, and San Diego are devoted to research in diabetes, one of the leading causes of illness and death among veterans. • VA and the National Parkinson Foundation have joined forces to seek a cure and improve treatments for Parkinson's disease, a major health problem among veterans and the general population. The Alliance to Cure

Department	VA Business Line and Activity
Private (cont'd)	among veterans and the general population. The Alliance to Cure Parkinson's Disease has initiated a variety of activities designed to enhance both organizations' work. • VA is in the process of developing an affiliation with the George Washington (GW) University School of Public Health that will enable VA to jointly recruit new staff to the HSR&D central office in Washington. Initially VA and GWU will jointly recruit a director of the Management Consultation Program. The affiliation will allow faculty appointments, teaching opportunities, opportunities to participate in research and possibly funding supplements. Training opportunities would also be made available for graduate students. • VHA has issued a contract for external accreditation of human subjects programs to the NCQA, an independent, not-for-profit accrediting organization that is nationally renown for it objective evaluations of health care organizations. **Medical Education** • VA's National Center for Patient Safety is providing training and advice in adverse event reporting systems to staff from the American Hospital Association, Joint Commission on the Accreditation of Healthcare Organizations, and Kaiser Permanente. **Housing** • VA executes the housing program through the private home building and mortgage lending industries. Most home loans are based on the automatic approval process that does not require VA underwriting approval before loan closure. • VA uses private sector management and sales brokers to manage and sell homes that VA acquires after foreclosure. **Insurance** • VA partners with the Prudential Insurance Company in administering and managing the SGLI/VGLI programs. VA meets with Prudential quarterly to discuss the performance of the SGLI/VGLI programs. VA works with Prudential in formulating new initiatives to help improve the programs. **Burial** • VA continues its partnerships with various civic associations that provide volunteers and other participants to assist in maintaining the national cemeteries. • VA works with funeral homes and veterans service organizations to increase awareness of burial benefits and services.

Communication

VA is committed to open, accurate, and timely communication with veterans, employees, and external stakeholders. We listen to their concerns to bring about improvements in the benefits and services we provide. The 2003 Performance Plan represents the roadmap that will guide the day-to-day operations and activities of VA staff around the country as we pursue the Secretary's priorities to improve claims processing, increase access to high quality health care, expand access to burial options, and maintain the national cemeteries as shrines. This plan identifies strategic goals, objectives, and performance goals specifically focusing on VA's key policy issues. For this to be an effective management tool, however, veterans, VA employees, and stakeholders must know about it and understand it.

To ensure we make our plan available to the widest possible audience, we use a combination of techniques to communicate it. Specifically, staff will be informed through our electronic mail system; in VA's publication, <u>VAnguard</u>; and in the Office of Management Bulletin. A press release will be issued to the general public informing them of the Performance Plan's availability. Anyone will be able to access the Performance Plan through VA's Internet Web site.

Tax Expenditure and Regulation

The Department of Veterans Affairs does not rely on tax expenditures or regulations to achieve program or policy goals.

Preparation of the Departmental Performance Plan

This plan was prepared entirely by employees of the Department of Veterans Affairs. VA's Office of Management -- in partnership with the Veterans Health Administration, the Veterans Benefits Administration, the National Cemetery Administration, and selected staff offices -- developed this plan. No contractor support was involved in the preparation of the plan.